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REGIONAL OFFICE FOR **Europe**

Early years, family and education task group: report



European review of social determinants and the health divide in the WHO European Region

By: Bjarne Bruun Jensen, Candace Currie, Alan Dyson, Naomi Eisenstadt and Edward Melhuish



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ABSTRACT

The task group on early years, childhood and family was set up as part of the European review of social determinants of health and the health divide in the WHO European Region, which was commissioned to support the development of the new health policy framework for Europe, Health 2020. The task group was asked to identify interventions, strategies and approaches that policy-makers and practitioners in the Region can use in the childhood years to improve and equalize health outcomes throughout the life-course. The report's analysis is organized in terms of early years and later childhood to reflect phases of children's experience that are distinct in many ways and which require different forms of service provision. Evidence comes from the international research evidence, a review of reports from transnational organizations, and case studies of illuminating practice from European countries. The report's broad conclusions should be considered in conjunction with more detailed recommendations provided throughout the text.

Keywords

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Foreword

The health policy framework for Europe, Health 2020, aspires to reach higher and further in making a difference to the lives of people in the WHO European Region. The journey of creating and adopting the policy included the commissioning of a number of studies and scientific reviews, one of the most important of which was the European review of social determinants of health and the health divide, led by Professor Sir Michael Marmot. The work of the review could not have been completed without the invaluable contributions of 13 task groups set up to consider evidence on how diverse countries across the Region can take action on the social determinants of health. The outputs of one of these groups – the task group on early years, family and education, led by Professor Alan Dyson and Dr Naomi Eisenstadt – is summarized in this report.

There is a substantial research literature in this field, with many transnational organizations producing evidence-based reports. But in addition to reviewing and evaluating such evidence, the task group wanted to find out about promising practices emerging in European countries. It therefore commissioned experts to submit case studies describing childhood and inequality issues within national and local contexts and initiatives launched to address them.

The richness of the task group's efforts, and those of the case study authors and others who supported the group's work, is reflected in this report. It recognizes that the foundations for the rest of life are laid in the childhood years and that much can be done – internationally, regionally, nationally, locally and within families, communities and schools – to guarantee that all children have a good start in life and consequently avoid inequalities in health outcomes. It focuses on vital stages of development – early years and later childhood, including the school years – with the 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 – being central.

The 53 Member States represent highly diverse social, cultural, political and material contexts, but the report highlights common underpinning principles that are necessary to give children across the Region the best start in the early years, the best opportunities in school and the best support as they move into early adulthood. In addition to strong political will and leadership, these include securing horizontal and vertical integration of policy and practice across governments and societies, collecting and using high-quality data, supporting the role of nongovernmental organizations and ensuring high-quality staff, management and leadership. Crucially, the report also calls for more evidence, particularly in relation to interventions for older children in community settings outside schools.

This report has already made a significant contribution to the European review of social determinants of health and the health divide and should be viewed in that context, but it also has inherent value as a stand-alone resource for policy-makers, professionals, parents, carers and young people throughout the Region. I urge you not only to read the report and consider its recommendations, but also to access the accompanying case studies of innovative practice: together they form a package that is both illuminating and inspiring.

Zsuzsanna Jakab

WHO Regional Director for Europe

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Acronyms and abbreviations

A PAR	Association Aprender em Parceria (Learning in Partnership Association) (Portugal)
ECEC	early childhood education and care
ENHPS	European Network of Health Promoting Schools
EU	European Union
HBSC	Health Behaviour in School-aged Children (study)
HCZ	Harlem Children's Zone (United States of America)
IVAC	investigation, vision, action and change (approach)
KIGGS	Studie zur Gesundheit von Kindern und Jugendlichen in Deutschland (National Health Interview and Examination Survey for Children and Adolescents) (Germany)
NGO	nongovernmental organization
NICHD	(Eunice Kennedy Shriver) National Institute of Child Health and Human Development
OECD	Organisation for Economic Co-operation and Development
PISA	Programme for International Student Assessment
PNNS	Programme National Nutrition-Santé (France)
SES	socioeconomic status
SHE	Schools for Health in Europe
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund

Early years, family and education task group report: recommendations

R.1 Introduction

This report focuses on the relationship between health and well-being outcomes and the family, school and community contexts in which children and young people develop. It is particularly concerned with what can be done to reduce health inequalities in the WHO European Region and draws on international research evidence, a review of reports from transnational organizations and case studies of illuminating practice provided by expert contributors from European countries. The report makes an inevitably arbitrary distinction between early childhood, from conception to the start of statutory schooling, and later childhood, from the start of statutory schooling to young adulthood, with detailed recommendations related to both.

R.2 Pregnancy and birth to statutory school age

The evidence for this review and from research indicates the critical importance of a good start in life for lifelong outcomes, including good health. While health services have the main role in ensuring health in pregnancy and safe births, social determinants have an effect even at this early stage in a variety of ways: diet before and during pregnancy, smoking during pregnancy and early parenthood, poor housing and poverty potentially affect outcomes.

Countries vary enormously in the provision of support at these very early stages, with the best systems being characterized by personalized ongoing support during pregnancy, choice in birth arrangements, postnatal support and advice, and paid parental leave for mothers and fathers.

Countries' provision of early childhood care and education for children before statutory school age also varies. An ideal system would involve high-quality, affordable and accessible child care that is sufficiently flexible to enable either parent to return to work. Nordic countries tend to have systems that combine all these features. Some wealthy countries, such as the United Kingdom, have greatly improved their systems in the last decade, but still have some way to catch up.

Poorer countries vary in their provision and attitudes to non-family care for very young children. Evidence nevertheless suggests that for children over two years, spending some time each week in stimulating and high-quality group care brings benefits and helps ensure that those from poorer backgrounds gain more. This represents an important poverty-reduction strategy, enabling parental employment and increasing family income.

Ideal provision includes multiple use for child care centres, including provision of advice and support on parenting, health and diet, and wider community use.

R.3 Later childhood

Virtually all countries in the European Region have universal and accessible primary education, and most have universal systems for secondary. Provision of universal primary and secondary

education for girls, as well as boys, is critical not only for child welfare and future health and well-being, but also for national economic growth, particularly in poorer countries.

Characteristics of systems that seem to reduce inequalities are non-selective entry to schools, systems to measure progress at child, school and area levels, and systems that encourage multiple use of school premises for a range of family and community services. Embedding health promotion into school curricula can also be highly effective, as it offers the best way to reach the broadest range of children and young people. Education systems that take account of differing social and ethnic backgrounds and work with the “grain” of family and ethnic identity are more likely to improve the progress of disadvantaged groups.

R.4 All children and young people

All nations in the European Region should aspire to achieve three overall goals by 2020.

1. Universal health protection coverage should be provided for pregnancy and childhood, which is particularly challenging for poorer countries in the south and east. Many have adopted mandatory insurance schemes, but the degree of services covered varies widely between countries. Smoking and rising obesity levels must be considered high priorities for all countries; this is an urgent issue that will create inordinate rises in health costs for the future if not addressed promptly.
2. Universal pre-primary, primary and secondary education provision should be in place in all countries.
3. Interconnected (rather than fragmented) systems should be developed across the age range, ensuring that education, social care and health are collaborative systems that share information appropriately, plan jointly on the basis of good data and local consultation and track the quality and acceptability of their services. This will result in greater efficiencies and higher user satisfaction.

Political will and dynamic governance systems are key to ensuring implementation of these recommendations. National governments need to signal financial and cultural support for what may be radical changes in some countries. Countries’ willingness to share experiences, exchange expertise and work together at international, national and local levels will be a critical factor in making progress. Recognizing that progress is (or is not) being made depends on rigorous data-tracking systems and clear baselines from which to measure change.

Early years, family and education task group report: executive summary

ES.1 Introduction

ES.1.1 The European review and Health 2020

The task group on early years, childhood and family was set up as part of the European review of social determinants of health and the health divide between and within the 53 Member States of the WHO European Region. The review is intended to support the development of the new health policy framework for Europe, Health 2020 (WHO Regional Office for Europe, 2012), and is informed by a social determinants perspective in which inequalities in health outcomes are traced to avoidable differences in the circumstances under which people live. The childhood years are particularly important from this perspective, because it is here that the foundations for the rest of life are laid. This task group report therefore focuses on what can be done to guarantee that all children have a good start in life and consequently forestall the emergence of inequalities in health outcomes.

ES.1.2 What is childhood?

Definitions of childhood have varied over time and between countries. It is defined in this report by a variable cluster of markers: social and economic dependence on family, participation in formal education, rapid physical development and special legal status. Phases of childhood are also variable but help to define requirements at different life stages: early years, the period before formal schooling; later childhood, once in school; and adolescence, beginning with the move from primary to secondary education.

ES.1.3 Childhood and health

Developments during childhood lay the foundation for physiological and psychosocial health and well-being outcomes throughout the life-course. Problems encountered early in life are not immutable, but are difficult and expensive to shift with increasing age. Children's development and experiences during childhood have long-term effects on health in adulthood. Overwhelming evidence shows that individuals who do well during childhood go on to enjoy better health outcomes over the life-course.

Doing well in childhood is defined by a range of indicators: educational attainment, physical development, social and emotional capacity for sustained relationships, and work-related capabilities such as persistence, team-working and reliability. Family and community contexts influence the development of these capabilities and traits: some families are more nurturing than others, some communities safer than others, and some political systems more supportive than others.

ES.1.4 Childhood inequalities

Children do more or less well depending on their biological endowments and the differing contexts in which they grow up. A strong correlation exists between less nurturant contexts in

childhood and socioeconomic status: children from poorer backgrounds are likely to grow up in such environments, which provide more limited opportunities and lead to poorer child outcomes and reduced life chances.

Inequalities associated with socioeconomic status form a gradient: the highest quintile do the best, the next quintile a bit less well, and so on. The problem is not just about the very poorest; these various contexts are by no means deterministic. Many children from poor backgrounds beat the odds and grow into productive healthy adults, perhaps due to their own personal agency or to protective factors within the family and/or community.

ES.1.5 The task of this report

This report aims to identify interventions, strategies and approaches that policy-makers can use to intervene in the childhood years to improve health outcomes throughout the life-course. The analysis is organized in terms of early years and later childhood. Where possible, the report focuses on system-wide approaches rather than particular evidence-based interventions. Making a difference to inequalities means making a difference across the range of contexts in which children develop and tackling the underlying causes of inequalities, as well as their more obvious manifestations.

The report's evidence comes from three sources: the international research evidence, a review of reports from transnational organizations, and a set of case studies of illuminating practice provided by expert contributors from European countries.

ES.2 Early years

ES.2.1 Setting the context

The definition of early years varies widely across the European Region. Early years, or early childhood, refers to children's experiences from conception to the start of statutory school, a milestone whose timing varies among countries. International evidence has consistently supported the proposition that the earliest years of a child's life, including antenatal experiences, set the foundations for future adult success. Services that support this stage of life, including health, education and social welfare, are intergenerational and multiprofessional in nature and are aimed at parents as well as children.

ES.2.2 The state of the art: what is already know

Brain architecture is established early in life through dynamic interactions between genetic and environmental influences: clearly, social policy and action can have a greater effect on the latter. The Marmot Review in United Kingdom (England) (Marmot Review Team, 2010) established incontrovertible evidence that progress could be made in reducing lifelong health inequalities if all children had the start in life typical of the most advantaged. The best systems for encouraging such a start include policies characterized by excellent health care in the pre- and postnatal periods, a benefit system that recognizes the risks posed by poverty in early childhood, good parental leave arrangements and high-quality early education and care.

ES.2.3 Mothers, fathers and family

Parenting practices are among the most pervasive and powerful environmental influences on children. Interaction with the primary carer in the first few months can set the journey towards healthy social and emotional development throughout life. Parental mental health plays a key role in outcomes for children; those of mothers with mental ill health are five times more likely to have mental health problems themselves, including emotional and behavioural difficulties. Fathers have a key role to play, both in reducing pressures on mothers and through their own nurturing capacity. Conflict between parents carries risks for children. Extended family ties, particularly involving grandparents, can enrich children's lives, providing support for parents and additional stimulation and care for children.

ES.2.4 The European context

Early childhood services comprise two main categories: parenting and family support, and early childhood care and education. Service delivery is dependent on sociocultural context and national economies. Attitudes towards female employment, out-of-home care for young children and the extent to which the state has a role in advising on parenting practices vary widely, reflecting national cultures. Southern cultures tend to favour a male breadwinner, establish residual social assistance schemes and support strong family independence. Other countries see support for child care within the context of gender equality, with strong systems in place to ensure women are not disadvantaged in the workplace. Child care subsidies, generous parental leave arrangements and flexible working are features particularly of Nordic countries. Somewhere between these two models sits the United Kingdom, which has improved its child care provision and parenting support to some extent.

Services in all countries tend to be either universal or targeted at particular groups deemed to be at risk, and are either formal, governed by clear procedures and performance arrangements, or more informal, relying on the judgement and expertise of front-line staff. Examples of these approaches can be found to some extent in most countries – virtually all, for example, will have universal provision of perinatal care – but very few, if any, have universal provision of structured parenting programmes.

ES.2.5 Early childhood education and care

Most countries have some form of publicly subsidised and accredited early childhood education and care for children below compulsory school age. Two models exist:

- a two-stage model, dividing ages 0 and 3–6 years
- a unified model that sees all age groups from birth to school as a single phase.

Research on the effect of early childhood education and care on young children shows that while long hours of group care pose some very small risks for those who are very young, all benefit socially and cognitively by the time they are 2–3 years. Those who are disadvantaged have the most to gain, particularly from high-quality provision.

Substantial evidence of the benefits of preschool experience is replicated in many countries, particularly for high-quality early childhood education and care, and was instrumental in the expansion of early years provision in the United Kingdom. Quality can be directly linked to better child outcomes, and cost–benefit analysis has also shown positive results. While the benefits are greater for disadvantaged populations, where the boost from high quality leads to reductions in crime, antisocial behaviour and future unemployment, the general population also benefits.

Early childhood education and care participation has grown substantially over recent decades, but progress towards the ideal Nordic country model is slow and is likely to be negatively affected by the European financial crisis. Data on European Region countries that are not European Union Member States are scant, but provision is likely to be limited. The extent to which early childhood education and care’s potential to address the challenges of inequality can be realized, particularly for traditionally excluded groups like Roma and migrant communities, depends on the design of the system. Universal provision makes it more likely that the inequalities characterized by the gradient of disadvantage will be addressed. Family support services are also critical, but can only ameliorate the impact of wider issues of poverty and disadvantage. They do not address the underlying causes of poverty.

ES.3 Later childhood

ES.3.1 Setting the context

Later childhood begins with the start of statutory school and finishes with the advent of young adulthood. It is a period when parent and family influences wane and those of peers, school and community grow. The emergence of strong personal agency is particularly important during this phase.

Policy-makers tend to look to schools as the principal means of making a difference to children and young people. Health provision can be patchy in poorer countries, but virtually all in the European Region have universal primary school provision and most have universal secondary provision. Children and young people nevertheless spend far more time out of school and many young people leave once statutory schooling is finished. Family, peer group and community therefore need to be considered in policy development for later childhood.

ES.3.2 The state of the art: what is already know

As in early years, children from poorer backgrounds are more likely than their more-affluent peers to experience ineffective parenting, attend inadequate schools and live in poor environments in later childhood. They consequently are more likely to have poor outcomes as adults. Poverty poses challenges to providing home environments conducive to learning, and socially segregated schools reinforce disadvantage. Parents’ access to employment not only reduces poverty, but also improves family routines and ensures children grow up understanding

work as part of adult life. Schools can work directly with children and other services to provide parents with support and advice on parenting strategies.

Adequacy and excellence are essential for improving educational outcomes. Ensuring sufficient school places is critical, but what happens in school beyond the numbers can also make a difference in addressing inequity. Countries' education systems should produce young people with the skills and knowledge to enable them to compete in a globalized economy and jobs market. Three features are critical to such a system:

- extending young people's opportunities to learn;
- delivering opportunities by well-trained teachers using effective pedagogy in well-organized schools; and
- aligning all aspects of the school system – curriculum, assessment, staff incentives and transitions between phases of education – towards learning.

Quality and equity need to be seen together. Inequalities in every education system relate to social differences in, for instance, social class, gender, migrant status and ethnic minority status. They are not confined to poorer countries; similar patterns are seen within richer.

Two strategies focus on inequalities of outcome:

- addressing inequalities of opportunities by ensuring the same quality of opportunity is open to all; and
- addressing inequalities of outcomes by providing compensatory services to ensure learners receive adequate support to overcome disadvantages.

Social determinants affect education and health outcomes. Efforts aimed at improving one set of outcomes will probably affect the other, but a strategy that addresses them simultaneously is likely to be more effective for both.

ES.3.3 The European context

The European Region is relatively affluent in global terms, but significant differences exist between countries, with implications for services provided for children and the outcomes children achieve. Inequalities among young people in Europe are particularly associated with patterns of migration. The affluence of many countries makes them a magnet for migration. Children who migrate with their parents may find themselves uprooted, receiving inadequate services and becoming relatively isolated in their host countries.

Promising strategies drawn from country case studies are outlined below. Not all have been rigorously evaluated, and those that have may have been implemented with a very narrow group of children and young people.

Early years, family and education task group: report

Armenia and France have had some success with coordinated approaches to health in young people. The Armenian programme aimed to improve access to health services and the French to focus on specific outcomes such as improving nutrition and physical activity levels. The programmes were quite different but shared key features for success, such as:

- leadership at national level and a strategic approach
- identification of clear priorities supported by quantifiable targets
- data collection to assess progress
- mobilization of a range of resources at all levels of the health system.

Hungary has had success with a programme designed to reduce accidental injury. Again, it included non-health agencies such as road safety and play and leisure organizations.

All initiatives identified in the case studies were heavily reliant on data. Data were used to specify the problem to be tackled, understand its causes, identify who was most affected (and therefore where interventions should be targeted), monitor implementation and progress and create a learning feedback loop.

School-based health programmes have also had some success. The most extensive was “Shape up”, a pan-European-Union programme focusing on overweight and obesity that used a health-promoting school approach. Its fundamental premise was that healthier eating and regular physical activity are key to preventing obesity. While the project did not focus on tackling inequality per se, it demonstrates that children and young people are able to initiate processes that improve determinants in their local environment and thereby promote the health of all children.

Cyprus, Denmark and France also provide good case studies of school-based programmes that focus on groups of children and young people who are particularly vulnerable to poor outcomes. Schools tend to reflect the social environment in which they are located, so those in disadvantaged areas can provide excellent settings for ensuring disadvantaged groups receive extra support. The danger of this approach is that many disadvantaged children do not live in, or go to schools in, poor areas.

The school-based examples lead to a rethinking of schools’ roles. The primary purpose is education, but some countries, including Belgium, the Netherlands and the United Kingdom, are looking to models of full-service or extended schools as a base for a wide range of community activities and services.

Another approach that aims to tackle the gap in achievement between more- and less-advantaged children is priority policies in education. These typically target additional resources at points of greatest need, either by individual risk or by particular groups at high risk of low attainment. Roma children have often been targeted in this way. Overall success has been mixed.

Area-based initiatives that target extra resources to particular disadvantaged neighbourhoods through a range of interventions such as physical regeneration, community development, school improvement and child care provision are similar to priority policies. Their drawback is failure to reach children who may have levels of disadvantage but do not live in a poor area, and the significant numbers of better-off families who live in poor areas.

Finally, inclusive education policies were originally designed to ensure children with disabilities were not marginalized and attended mainstream schools with adjustments and supports relevant to their disabilities. Inclusive education began to take on wider issues of social exclusion, including poverty and ethnic minority status. Efforts in Poland were hampered by parents' resistance to inclusion strategies: this experience is not atypical, as some parents fear the effects of mixed-ability groups on education quality.

ES.3.4 Overarching integrated approaches

Many of the strategies and approaches described above rely on bringing together a range of services and tackling issues simultaneously and in a coordinated way. Ambitious attempts have been made in Europe and elsewhere involving the development of long-term, wide-ranging strategies and/or the formal integration of services for children and families. The “Every child matters” initiative in United Kingdom (England) was an example of ambitious efforts to integrate services for children and families at all levels and across professional boundaries. The current United Kingdom government seems less committed to this approach than the previous administration, but cultural changes established at local level seem to be proving robust. Given the choice, many local areas are continuing with partnership working.

ES.4 Conclusions

ES.4.1 Early years

High-quality perinatal care available to all is the essential bedrock of early years services. Adequate paid parental leave is potentially beneficial to promoting parents' well-being and facilitating attachment, which is essential for infant mental health and breastfeeding. High-quality, flexible and affordable early childhood education and care completes the fundamental infrastructure of good early years systems. Given its proven benefits, preschool experience for all children should be available whether parents are working or not. Family support and parenting programmes and health and well-being support based in early years settings are valued additions and help to ensure the widest possible usage of services by priority groups.

ES.4.2 Later childhood

Short-term interventions can be effective but are often limited in scope and are never transformative. More sustained, wide-ranging, integrated and powerful strategies are needed to make a substantial difference. A social determinants approach will typically require coordinated cross-systems strategies and perhaps structural reform, but structural reform alone will not be sufficient to deliver necessary change. Local action can make a difference, particularly if

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teachers, primary care staff and local policy-makers work together towards achieving common goals. Schools have critical roles to play in addressing unequal outcomes by focusing effort on learning, welcoming local partners' contributions on family support and fostering children's and young people's self-efficacy and agency.

ES.4.3 All children

Children need to grow up with adequate material resources in families capable of offering effective support and with access to real education opportunities. Guaranteeing these conditions represents a major contribution to increasing equity and improving outcomes.

Political will and leadership play a crucial role in getting systems to change. Signals from the top give all players licence to work together on stated aims and reforms to make change happen. Leadership is important at every level, from head of state to local school head teachers. It galvanizes action and isolates change-resisters.

All the case studies illustrate the importance of a multistrand, multilevel approach. Service integration and collaboration ensure momentum of combined efforts and reduce duplication.

Service users' experience must be aligned with data analysis. Users' engagement in design will ensure they get the services they want; data analysis will identify who is not coming forward, help to find ways to bring them into the system, support efforts to measure progress and provide crucial information on what needs to be improved.

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1. Introduction

1.1 The European review and Health 2020

The task group on early years, childhood and family that produced this report was set up as part of the review of the health divide between and within the 53 Member States of the WHO European Region (WHO Regional Office for Europe, 2013a). The review, chaired by Professor Sir Michael Marmot, is intended to support the development of the new health policy framework for Europe, Health 2020 (WHO Regional Office for Europe, 2012).

Both adopt a social determinants perspective on inequalities in health outcomes that focuses on the ways in which inequalities can be traced to avoidable differences in the circumstances under which people live. As WHO's Commission on Social Determinants of Health (2008) argues:

The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life.

It follows that tackling health inequalities is not only about finding improved treatments for illness, nor even tackling the more immediate causes of ill health such as smoking, diet and alcohol. It is also about tackling the “causes of the causes” (Commission on Social Determinants of Health, 2008) in the form of the circumstances under which people live and the inequalities within them.

Health 2020 and the European review also adopt a life-course perspective on understanding health inequalities, tracing outcomes at one stage of life to the accumulation of experiences at earlier stages. The childhood years are particularly important from this perspective. It is here that the foundations for the rest of life are laid, long-term outcomes are shaped and many adult health inequalities have their origins. This may mean it is often too late to tackle health inequalities once they have become fully apparent, but it also opens the possibility that their emergence could be forestalled if all children could be guaranteed a good start in life.

The social determinants perspective indicates a key role for policy-makers, practitioners and communities. The circumstances under which people live are not fixed and can be changed by action at national and local levels. Health 2020 and the European review therefore focus on what can be done across all sectors and all levels of government, emphasizing the importance of collaboration in the pursuit of common aims. The idea that children's experiences can be changed by what policy-makers, practitioners and communities do and that inequalities in those experiences can be eradicated or reduced is also fundamental to this report.

Practical and research-based knowledge on what is likely to make a difference exists. The report therefore seeks to offer practical guidance and real- world examples of promising actions that have been taken forward in different parts of the European Region. The task group has nevertheless been aware throughout of the Region’s diversity and of the dangers of transplanting practices from one place to another without taking into account their very different circumstances. Ultimately, therefore, it is for readers to make sense of the ideas and examples in their own contexts.

1.2 What is childhood?

This report is concerned with the relationship between what happens during childhood and health outcomes in childhood and later in life. It views childhood as the loosely-defined period between birth (or, for some purposes, conception) and adulthood, during which biological, cognitive and personal development is at its most rapid.

The period is loosely defined for a number of reasons. One is that definitions of childhood and adulthood are culturally based. Childhood ends early in some cultures, with young people taking on significant social and economic responsibilities, but is protracted in others, where they remain dependent on their families long beyond the point at which they reach physical maturity. Definitions are also affected by the organization of institutions and services. Countries draw the boundary between childhood and adult services and define child and adult status within legal systems differently: indeed, the same system may vary the child–adult boundary for specific aspects of legal status, meaning young people may be able to marry before they can vote and may be held criminally responsible long before either.

It is therefore best to regard childhood as being defined not by fixed age limits, but by a variable cluster of markers such as social and economic dependence on the family, participation in formal education, rapid physical development and special (usually protected) legal status. The same goes for distinctions sometimes made between phases within childhood – infancy, early childhood, adolescence and so on. These cannot be defined precisely in a way that applies to all contexts and children, but nevertheless offer a useful shorthand means of referring to complex stages of development.

The report draws a broad distinction between the early years, before children enter statutory education, and later childhood, once they are in school. It also refers to a similarly broad distinction between children and young people, the boundary being marked by the onset of adolescence and (in many systems) by a transfer from primary or elementary school to secondary education. These distinctions are, however, by no means hard and fast.

1.3 Childhood and health

What happens in childhood is important for health outcomes in two ways. First, the rapid biological, cognitive and social developments taking place in childhood give rise to distinctive health outcomes. Children are particularly vulnerable to a range of health risks, but are relatively

free from many of the health problems related to ageing or environmental dangers that affect adults. Perhaps more important from a social determinants perspective, developments taking place during childhood lay the foundation for health outcomes throughout the life-course. This is certainly true biologically, where weaknesses and problems developed during childhood may have a life-long impact on health, but it is also true psychosocially, with children developing habits of mind and relationship that may prove difficult to change in adulthood.

Childhood, however, also has a more indirect effect on health. Children's development and experiences during childhood do not produce health outcomes in the short term, but have a longer-term impact on how healthy they will be as adults. Much of childhood is about establishing who individuals are and how they will live. It is a period in which attitudes, values and behaviours become established, when children acquire skills and knowledge, and when their encounters with societal environments begin to open up, but also close down, opportunities. These shape what will happen to individuals in later life – what kind of relationships they will have, what work they will do and how they will view themselves – and therefore affect the health outcomes they will achieve.

Not surprisingly, therefore, the evidence for individuals who do well during childhood going on to enjoy better health outcomes over the life-course is overwhelming (WHO, 2007). Doing well in this sense, like childhood itself, is best defined in terms of a variable list of indicators that are dependent to some extent on cultural and systemic contexts. The list is difficult to pin down precisely but certainly includes achieving specific physical capacities and characteristics, being able to sustain a range of relationships and to handle a variety of social situations, having the capacity to take well-informed and considered decisions about one's own life and acquiring cognitive skills and knowledge that will be useful in adulthood, each of which may be formally accredited within the education system.

To some extent, doing well is about developing the individual's innate capacities, but thinking only in terms of an internally driven developmental process is far too simplistic. Children develop within, and in interaction with, a range of environments and contexts (Dyson et al., 2009), including family (which in many ways is the most influential), peer group, community and service environment – most notably, school. Insofar as these contexts are nurturant (Dyson et al., 2009), they enable the child to develop and achieve good outcomes, but they are not equally so for all children; some may limit or even pervert development. Children can and do develop in ways that limit their life chances, turning them into unhappy adults and leading to risky or unhealthy behaviours.

The kind of life a child will go on to lead is not solely dependent on how he or she develops. Contexts in which children develop open up or close down opportunities for how capacities developed during childhood can be exercised during adulthood. Families, for instance, can not only nurture more (or less) healthy, confident and skilled young people, but can also set them on different trajectories, helping (or failing to help) them to access education or employment

opportunities. In the same way, communities and places offer young people opportunities or impose constraints as they move into adult life.

1.4 Childhood and inequalities

This is the point where the relationship between childhood inequalities and health inequalities becomes significant. Children do more or less well partly because of their biological endowments but also partly (indeed, many would argue, largely) because of variation in the contexts within which they develop. Relationships between these contexts are complex. It is not necessarily the case that the nurturant quality of one context will be paralleled by the quality of others. For this reason, the risks generated by a context can be countered by more nurturant factors in another, allowing children to become effectively resilient in the face of those risks and enjoy good outcomes (Schoon, 2006).

Neither are these contexts entirely independent of the other; poor quality in one increases the likelihood of poor quality in others (Duckworth, 2008). Socioeconomic status (SES) seems to underlie many differences in childhood outcomes. Put simply, children from poorer backgrounds are likely (though, of course, by no means certain) to grow up in less nurturant contexts that provide more limited opportunities, leading to poorer childhood outcomes, reduced life chances and, ultimately, poorer health outcomes (Cassen & Kingdon, 2007). A perfect storm of poverty exists in some cases, with inadequate parenting, poor childhood health and ineffective schooling leading to a reproduction of the poverty into which the child was born.

The issue of childhood inequalities, however, cannot be reduced simply to a question of what happens to the poorest. Variations in SES take the form of a more-or-less smooth gradient rather than a plateau with a “cliff” over which a minority of very poor people fall (Commission on Social Determinants of Health, 2008). Not surprisingly, the gradient in childhood outcomes tends to parallel that of SES.

To complicate the matter further, other social characteristics such as ethnicity, gender, migrant status and disability interact with SES in different ways. To take two examples, the Organisation for Economic Co-operation and Development (OECD) reports that disabled young people in many countries typically experience particular difficulties in translating their capacities into good adult outcomes (OECD, 2011), while the European Commission Directorate-General for Employment and Social Affairs (2005) has shown that Roma people across Europe experience difficulties that are not simply related to SES.

It is also important to note that children themselves are not exclusively products of the contexts within which they develop. On the contrary, they are agents in that development and shape their contexts as they themselves are shaped.

Any parent or teacher knows that children are not passive; what appears to be the same family or school context not only affects different children differently, but is also changed by them in different ways. This agency is important in terms of childhood outcomes in general and health

outcomes in particular. Put simply, children are made healthy by, and make themselves healthy through the way they interact with, their environment.

1.5 The task of this report

In this context, the European review set the task of identifying interventions, strategies and approaches that policy-makers and practitioners in the European Region can use to intervene in the childhood years to improve and equalize health outcomes throughout the life-course. Given the size of the task and the limited resources at the task group's disposal, the work inevitably had to be divided and boundaries set in ways that are hopefully not entirely arbitrary.

The analysis is organized in terms of early years and later childhood. This division is necessarily crude but reflects phases of children's experience that are distinct in many ways and which require very different forms of service provision. The family (however defined) forms the principal context in which children learn and develop in the early years, and health and social care are the services with which they are likely to have most direct contact. In later childhood, children and young people explore with increasing autonomy a range of contexts beyond the family, and education is likely to become the dominant service with which they interact: indeed, much of the evidence on improving and equalizing outcomes in later childhood comes from interventions undertaken by, or in association with, schools. There are good reasons why this should be so, given the key role played by schools in promoting children's development and offering a point of access to other services. It may nevertheless indicate the relative neglect of other contexts, on which the report comments.

A cut-off point of the end of statutory schooling was set for the analysis. This means, of course, that it does not deal with important issues in the transition to adulthood, particularly as they affect young people in disadvantaged circumstances (Iacovou & Aassve, 2007). Neither does it deal with issues in tertiary education and lifelong learning. All of these are important, but are for other task groups to address.

The work focuses on identifying interventions, strategies and approaches rather than on documenting the extent of childhood inequalities and their relationship to health inequalities. It is beyond the report's scope to set out a comprehensive analysis of the European research evidence in this field. Other than the brief account set out above, inequalities and their interrelationships are taken as read, with the report concentrating instead on what can be done about them.

The formulation of interventions, strategies and approaches is somewhat clumsy but has been chosen quite deliberately. The temptation for researchers, as for policy-makers and practitioners, is to focus on tightly prescribed and targeted interventions that aim to change particular outcomes for identified groups of children. Such interventions are (relatively) easy to implement and evaluate, and they have their place. The analysis set out above suggests, however, that limited interventions of this kind are unlikely to make a significant, large-scale difference to childhood inequality. Making a difference to inequalities means making a difference across the

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range of contexts in which children develop and reaching down to the underlying causes of inequalities as well as their more obvious manifestations. For this reason, the analysis also needs to focus on more wide-ranging practice approaches and policy strategies.

The evidence comes from three sources. The task group did not have the capacity to undertake a comprehensive and multilingual search for evidence, but was by no means the only task group to have explored this field. Many transnational organizations have produced reports on one or more aspects of childhood inequalities. The recommendations in these reports were reviewed with the aim of differentiating between those that are, and are not, evidence-based. These reports are considered to articulate the state of the art in the field: their recommendations are not unproblematic, but the main concern has been to understand what they might mean in the European context.

Second, a series of case studies of developments in a range of European countries was commissioned. The case studies are written by local experts and report on promising initiatives to tackle childhood inequalities. The emerging picture is inevitably somewhat patchy in terms of geographic coverage and the quality of evidence available. It was stipulated that case studies had to be presented in English, and it proved easier to gather evidence-based accounts of substantial initiatives from more-affluent countries with well-established services – notably those of northern and western Europe. They nevertheless cover a range of contexts and, perhaps most important, offer accounts of what has been possible in practice within these contexts, moving beyond the articulation of decontextualized principles. The report quotes and adapts freely from the case studies throughout, but the full texts are available online (WHO Regional Office for Europe, 2013b–d).

Finally, the report draws on task group members' expertise and, more specifically, their understanding of international research evidence in this field. Group members work on a range of issues in childhood and health and their interests, biases and language limitations are inevitably reflected in the report. Conscious efforts have been to moderate these by setting them in the context of the case studies, the review of transnational reports and expert reviewers' and advisers' alternative perspectives.

The report focuses throughout on actions that can be taken by policy-makers, practitioners and communities within particular national contexts. It is also about what countries can learn from each other and how they can be supported to prioritize and develop actions to tackle inequalities. In this regard, there is a clear part to be played by organizations such as the WHO Regional Office for Europe that can work at a supra- and international level. They can, among other things, facilitate the sharing of experience, develop common frameworks for action and make comparative data available. Exploring such organizations' roles in detail is beyond the report's remit, but their presence is clear throughout.

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2. Early years

2.1 Setting the context

The definition of early years differs widely across the European Region. Early years (or early childhood) refers to children's experiences from conception to statutory school age, which varies from country to country. Children in some areas start school as young as four years and in others as late as seven. This has often led to unfair comparisons across countries on early years spend: it includes expenditure up to seven for some countries that is counted in the statutory school spend in others.

The most common age for starting compulsory school in Europe is 6 years, so 0–6 can be regarded as early childhood for the purposes of this report. Nearly 1 in 8 households in Europe, (12%) is caring for a child under the age of 6, but the figure is more than 15% in, for instance, Cyprus, Portugal and Spain and less than 10% in Bulgaria, Finland and Germany.

International evidence has consistently supported the proposition that the earliest years of a child's life, including antenatal experience, set the foundations for future adult success. This is not to say that a poor start in life determines poor outcomes later on, but confirms that a difficult start is expensive and challenging to overcome. Various socioeconomic factors, including poverty, belonging to disadvantaged social classes, low parental education and religious or cultural traditions in which literacy is not highly regarded, can have a negative effect on children's health and development. One factor alone may not be decisive: rather, it is the combination that leads to serious consequences for child development. Services that support this stage of life, including health, education and social welfare, are intergenerational and multiprofessional in nature and are aimed at parents as well as children.

This chapter considers approaches to service delivery that are aimed at child development outcomes either directly for children or indirectly through parent support. Other critical issues to family well-being, such as housing and transport, are not discussed.

2.1.1 The state of the art

Brain architecture is established early in life through dynamic interactions (epigenetic processes) between genetic and environmental influences. Evidence on how environmental factors influence the timing and nature of gene expression is accumulating. Experiences sometimes stimulate or inhibit neural connections at key developmental stages referred to as sensitive periods (see Fox et al. (2010) for a review). Potent influences can occur before birth and during the first 18 months of life. The antenatal period is as important as infancy to child outcomes, as maternal behaviour has strong effects on the developing fetus. Fetal alcohol spectrum disorder is one of the leading causes of intellectual disability and psychosocial stress during pregnancy has been linked with increased risk for behaviour problems.

The Marmot Review (2010) established incontrovertible evidence that progress could be made in reducing lifelong health inequalities if all children had the start in life typical of the most advantaged. The virtuous and vicious cycles are well established and start before birth. A good start is characterized by a mother who is healthy during pregnancy and gives birth to a baby with a healthy weight; the baby then experiences warm and responsive relationships in infancy, has access to high-quality child care and early education and lives in a stimulating environment that allows safe access to outdoor play. Children who experience such a positive start are likely to do well at school, attain better paid employment and enjoy better physical and mental health in adulthood. Babies with mothers who smoke or drink during pregnancy, who have a low birth weight, suffer from insecure attachment, experience a poor language environment, are exposed to frequent harsh verbal interactions and miss out on high-quality preschool education will start school at a significant disadvantage.

The best systems for families with young children include policies characterized by excellent health care in pre- and postnatal periods, a benefit system that recognizes the risks posed by poverty in early childhood and provides adequate support, good parental leave arrangements and high-quality early education and care. Most depressingly, the gap between children with good and poor early environments widens through the school years: school therefore does little to mitigate the impact of a poor early childhood. While none of the above conditions are rigidly determined by social class, they are closely associated with the social class gradient.

2.1.2 Mothers, fathers and family

Parenting practices are among the most pervasive and powerful environmental influences on children. Much is now known about the importance of the home environment and how parents interact with their babies and young children from birth. Brain architecture, particularly for emotional development, is established in the first years of life. While brain development continues well into adulthood, interaction with the primary carer in the first few months can set the journey towards healthy social and emotional development throughout life (Fox et al., 2010). Long-term physical health trajectories are set very early, including risks of obesity, heart disease and mental illness (Dyson et al., 2009). Cognitive outcomes are also influenced in the very early months, with a strong association between breastfeeding and cognitive skills (Borra et al., 2012). Cognitive, language and social development are influenced in the longer term by the quality of the early years home learning environment (Melhuish et al., 2008a; Melhuish, 2010).

Much of the evidence has focused on the quality of the child's attachment to key caregivers, typically parents. Children with an insecure attachment are more likely to have social and emotional difficulties such as increased domestic violence (Dutton & Corvo, 2006), higher alcohol and substance abuse and multiple sexual partners (Walsh, 1992) later in life.

Insecure attachment has been linked to poor physical health in adulthood, including strokes, heart attacks and high blood pressure (McWilliams & Bailey, 2010), but secure attachments are

associated with healthy behaviours such as taking part in physical activity, not smoking, not using substances and alcohol and driving at ordinary speed (Huntsinger & Luecken, 2004).

It is not surprising that parental mental health also plays a key role in outcomes for children. Overall, children of mothers with mental ill health are five times more likely to have mental health problems themselves, resulting in emotional and behavioural difficulties (Meltzer et al., 2003). Parental mental illness (including substance abuse), particularly in the mother, is associated with poor birth outcomes, heightened risk of sudden infant death and increased mortality in offspring.

Fathers have a key role to play. Sharing the parenting role reduces pressures on both parents and improves mothers' capacity to work, increasing family income and decreasing the risk of poverty. Children whose fathers have mental health disorders, however, are likely to have psychiatric or behavioral disorders themselves; boys in particular can be affected if their father has depression or alcoholism. Children are also affected, for good and ill, by the quality of relationships between their parents. Intensive parental conflict and witnessing domestic violence have been shown to have long-term negative impacts on children (Coleman & Glenn, 2009).

Grandparents can play a vital role in early childhood development and enrich lives throughout the formative years. They can support parents in rearing children, providing moral support, stimulation and care for children and sharing their own childrearing methods. Multigenerational families therefore have advantages.

2.2 The European context

Early childhood services consist of two main categories:

- parenting and family support
- early childhood education and care (ECEC).

Early childhood service provision is dependent upon sociocultural contexts. Industrialized societies have seen marked increases in maternal employment in the last 50 years, with countries responding differently to increased demands for child care and family support. Child care provision is seen as a state responsibility in some: 85% of mothers of a preschool child were in employment in the early 1990s in Sweden, for example, which provides high levels of publicly funded ECEC. Elsewhere, child care and parenting are seen as private concerns and limited publicly funded services are available. The quality and type of services in these circumstances will be more diverse. Where costs fall to parents, they are likely to choose on the basis of cost, particularly as information on quality may not be readily available; where services are publicly funded, cost constraints are reduced and service quality is usually regulated to minimum standards, with training for professional staff. Other factors such as parental leave will also influence early childhood services.

Nested environment influences on child development present in a hierarchy. Culture and social context (labour markets and ideology, for example) affect the provision of early childhood services such as family support and child care, which in turn influence the daily experiences of children at home and outside home. These daily experiences are the engine of child development (Melhuish, 2005).

2.2.1 Parenting and family support

Countries have adopted different approaches to what has been termed family support, that is, programmes and benefits aimed at adults that are designed to affect their children. Cultural norms and beliefs that parenting support and education are private family issues to be determined by the adults involved prevents involvement in many countries. Familism has always been a core component of the social structure in Greece, as in other southern European countries (southern Italy, Portugal and Spain). It implies strong family ties, intergenerational obligation and the family as the primary locus of social solidarity (in relation to care and support provision) and productivity (in terms of economic activity). These countries tend to favour male breadwinners enjoying higher employment protection and job stability than other labour-force groups such as women and migrants. Social assistance schemes are residual, with child and elderly care being provided mainly by family. Unemployment compensation, vocational training systems and welfare-state institutions are relatively undeveloped (Karamessini, 2008).

Debate about the state's role in intervening in family life is ongoing in most countries, but acceptance that the state has a clear role when child safety is put at risk is universal. Some have taken an active approach in reducing pressures on families. Generous subsidies for child care, flexible working arrangements and parental leave entitlements take stress off families and encourage more time with children. Encouraging the delivery of parenting programmes and interventions is more about improving parents' capabilities and skills than removing pressures that impinge on family life. Reports in the United Kingdom (Field, 2010) have suggested that the key to ending child poverty lies in the current generation of parents' ability to ensure that children grow up with the skills and confidence to avoid poverty as adults. Such interventions have nevertheless rarely been brought to scale or subjected to long-term evaluation studies, so the impact on intergeneration mobility and reduction of future inequalities is as yet unknown. Parenting programmes also have great difficulty in targeting the most appropriate families for interventions and maintaining their engagement, with up to 50% of those eligible being missed.

Many nations offer elements of approaches to reduce pressures and improve capabilities. A balanced combination would seem to be most promising, as the ability and motivation to improve parenting styles is more likely to develop when mothers and fathers are not struggling with the fundamental basics of providing food and shelter for children.

Different typologies in relation to parenting and family support services can be distinguished: those that are either targeted or universal, are standardized through a manual or fixed set of activities, or are more informal, relying on practitioner judgement. Baby and toddler health

centres in the Netherlands provide an example of universal parenting support. Many municipalities in the country have been involved in restructuring services and have launched family-support systems such as a front-desk post for youth health care, culminating in centres for youth and family that include the baby and toddler health care centres.

The centres, which are located in neighbourhoods, can be easily reached and are free to visit, have three main responsibilities: vaccination, screening of health and physical development problems, and educating young parents on nutrition, hygiene and family health care. They share some features of the “Sure start” children centres in the United Kingdom which, up until 2010, had been rolled out in a manner that would have culminated in a universal service. Recent changes in government and economic forces in the United Kingdom have resulted in a policy change, with “Sure start” now becoming more targeted on disadvantaged populations; in addition, increasing emphasis on local government control is resulting in greater regional variation in the characteristics and adequacy of services available.

Targeted parenting/family support is usually about preventing poor outcomes for at-risk groups. Traditional approaches are often based on a medical model which implies that poor outcomes have specific causes and that specific treatments can break the link between cause and effect. An alternative ecological multiple-systems approach that presumes complex non-linear relationships between early events and later outcomes mediated by chains of transactions between the individual and the environment has been gaining ground.

The most common form of family support is rather informal, based largely upon individual practitioner judgement. The next is systematic manualized individual interventions, such as “Triple P”, “Incredible years”, the Home Instruction Programme for Pre-school Youngsters and the family–nurse partnership. Some of these (such as “Incredible years” and the family–nurse partnership) have been subject to rigorous evaluations that provide substantial systematic evidence to support their efficacy, while others have no such data. Evidence on individually based parenting programmes has recently been reviewed (Schrader-MacMillan et al., 2012) and can be summarized as follows.

2.2.1.1 Parenting programmes delivered by health professionals

The manualized family–nurse partnership home visiting programme in the United States of America has shown long-term beneficial effects. The programme is provided for vulnerable mothers from pregnancy to two years postnatally. Findings to date in the United Kingdom show positive trends in level of acceptance by young first-time mothers, engagement of fathers, improvement in some health behaviours and parents’ preparation for parenthood. No evidence of effects on parental psychological health, infant functioning or development has yet been found, but evaluation work is underway.

There is some evidence that less structured interventions from health visitors can be beneficial in enhancing maternal sensitivity for mothers considered at risk for child abuse.

Relatively short programmes of professional home visiting that incorporate video interaction guidance designed to enhance infant attachment and mother–infant interactions have been tested in the Netherlands with mothers with clinically diagnosed levels of depression and other co-morbid symptoms and children with temperament difficulties. Evidence of short-term improvements in maternal sensitivity and longer-term reductions in child externalizing behaviours has emerged. The approach is particularly useful for mothers of highly reactive infants (those who are particularly sensitive to stress) and could potentially be an important method of supporting vulnerable mothers who might find it difficult to be involved in longer-term programmes.

2.2.1.2 Programmes delivered by paraprofessionals and volunteers

There is some evidence that the “Start well” programme has the potential to improve maternal psychosocial health and the quality of the home for supporting optimal child development, probably due to the fact that health professionals provided some of the home visits, working alongside paraprofessionals. Programmes delivered by volunteers, including peer mentoring and “Home start”, show no evidence of persistent effects on children, but the evidence for volunteer-delivered programmes that follow a structured itinerary, such as “Let’s play in tandem”, a programme delivered in United Kingdom (Wales) as part of a wider initiative focused on enhancing preschool children’s emotional and cognitive development, is more promising. The effect of this peer-provided programme can in part be attributed to the combination of home visits with centre-based activities for children and detailed training for parent providers.

2.2.1.3 Integrated model of delivery of multiple services

These approaches are becoming increasingly common. Parent and child centres used in Amsterdam, the Netherlands since 1997 represent an integrated service innovation designed to stimulate better parenting, identify social and health risks at an early stage and offer early interventions for parents and/or children. They offer integrated multidisciplinary services with easy access in a community setting for parents (to be) and children, providing advice, information and parenting support, making referrals to secondary care and maintaining strong relationships with special education services and general practitioners (Darwish & de Vries, 2010). Centres were developed bottom-up by professionals and evolved into a city-wide system change in multidisciplinary services.

Amsterdam’s centres have been pioneering the service in the Netherlands, but are a work in progress that need more uniform multidisciplinary protocols to create a fully client-centred service system. They are nevertheless regarded as an improvement over the former system.

“Sure start” in United Kingdom (England) provides a more widespread example that represents an integrated approach to early years intervention which seeks to integrate all services for parents and children, from pregnancy until the start of school. The principal goal of “Sure start” local programmes was to enhance the health and well-being of young children in disadvantaged

neighbourhoods. By improving children's developmental trajectories, the local programmes aimed to break the intergenerational transmission of inequalities in health, poverty, school failure and social exclusion. They were set up between 1999 and 2003 to develop different ways of providing services in deprived communities, initially on an area basis, with all young children and their families living in a defined geographic area being the targets of intervention. They were established in the 20% most-deprived areas and approved upon application by a partnership of health, education, social services and voluntary sectors.

In contrast to interventions targeted at individual families, "Sure start" local programmes did not initially offer a prescribed set of services, particularly those delineated in a manualized form to promote treatment fidelity to a defined model. Instead, each was charged with working with the community to improve existing services according to local needs while covering core services – outreach and home visiting, support to families and parents, support for good-quality play, learning and child care, primary and community health care and support for children and parents with special needs – but without specifying how services were to be changed.

Early evidence from the "Sure start" evaluation showed that while the community development model was working for most families, it was not having an effect for the most disadvantaged. The model of service delivery was consequently changed: "Sure start" children's centres were introduced to deliver a core set of services, including child care, health and employment advice and parenting support, with an emphasis on reaching the most vulnerable. The number of centres was hugely increased, with the aim of having a "Sure start" children's centre in every community.

Subsequent political and economic developments have resulted in "Sure start" children's centres being scaled back to serve deprived areas and families rather than the total population. The latest evaluation evidence of their impact indicates that benefits are being sustained for parents but not for children in the longer term, indicating that further work is needed to improve the daily experiences of deprived children (National Evaluation of Sure Start Research Team, 2012).

Parent and children centres in the Netherlands and "Sure start" in United Kingdom (England) had strong health input. Including health is important for three reasons. First, health professionals tend to be very well trained. Second, health organizations have very good data on where families are, which is particularly important in offering prenatal and early postnatal support. And third, health services are universally acceptable to families: they carry no stigma and their core purpose is readily understood.

Difficulties are frequently encountered in establishing integrated services that include health, education and social care, as different bureaucracies and professional traditions can interfere with successful integration. Co-locating health services alongside other forms of family support

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ensures uptake and is more convenient for families. Co-location and joint staff training sessions can often help achieve integration among staff of different disciplines.

2.2.1.4 Community-level family support approaches

Community-level family support approaches are less frequently used, but are increasing. An example is Association Aprender em Parceria (A PAR) (Learning in Partnership Association) in Portugal. Portuguese cities lack effective support for families with babies (from birth to three years). At-risk families tend to be single parents, adolescents with babies and socially excluded people, many of whom are unemployed and whose children leave school early.

A PAR was created to support parents of young children in disadvantaged communities. It was developed from the “peers early educational partnership” model (Evangelou et al., 2007), combining individual and community approaches to promote:

- positive bonding between parents and children
- self-esteem
- positive dispositions towards learning, curiosity and confidence
- educational achievements among children, especially in literacy and numeracy
- reductions in school dropout rates
- social support between families and inside the community.

A PAR groups include:

- circle time, with parents, carers and children being led in carefully chosen songs and rhymes to promote relationships – all families are offered a songbook containing the songs and rhymes used in the programme;
- story time, with story-telling in every session;
- book sharing, offering books for parents to share with their children during group time;
- talking time, enabling adults to discuss ideas, share experiences and offer and receive support;
- borrowing time, using a library of play packs, books and play materials offered weekly; and
- home activities, including practical suggestions for games and activities.

The A PAR mission is to create confident communities, learning together with their children. Systematic evaluation revealed that parents received several benefits in relation to their capacity to interact with their children, ability to observe their daily progress and to recognize the most important moments of interaction with their child, and understanding that they are their child’s most important role models. A PAR enabled them to enjoy parenting activities and seek social support. Children also appeared to show improvements in self-esteem, cognitive development, literacy and numeracy.

2.3 ECEC

Many countries have some combination of formal and informal family support but, with the exception of well-developed systems for the provision of health services, very few have mature systematic programmes. This is in sharp contrast to ECEC systems.

Virtually every country in Europe has set up some form of publicly subsidized and accredited ECEC for children below the compulsory schooling age. Differences lie in organizational forms, subsidy levels, responsible authorities and the age at which children can access provision. Public authorities in many countries offer subsidized places from a very early age, often from the end of statutory maternity leave, but this does not necessarily mean that demand for places is fully met.

Two organizational models for ECEC services exist in Europe. Under the two-stage model, services are structured according to children's age (normally 0–3 years and 3–6). The 0–3-year-olds often come under health or social service responsibility, with the older group under education administration. A newer unitary model has been adopted in countries with a longer history of ECEC provision, with a single phase for all children of preschool age. Each setting has a management team for children of all age groups and staff may have the same qualifications and be on the same salary scales regardless of the children's ages. The unitary model is preferred in Nordic countries (excluding Denmark), Latvia and Slovenia. Both models coexist in Cyprus, Denmark, Greece, Lithuania, Spain and the United Kingdom.

All European Union (EU) countries have accredited and subsidized ECEC services, but there is little publicly funded provision for 0–3-year-olds in some that operate a two-stage ECEC model (the Czech Republic, parts of Germany, Greece, Ireland, the Netherlands and Poland) and the participation rate in subsidized settings is very low. ECEC systems in some countries suffer from haphazard and poor regulation, lack of resources and, consequently, poor quality and limited provision. Problems may be compounded outside the EU and in countries that have experienced conflict or sudden political transitions by a loss of the infrastructure that had previously been established: in Ukraine, for instance, availability of preschool places reduced by 39% between 1990 and 2004, with a particular lack in rural areas and over-enrolment in urban areas in which facilities existed (Zinchenko et al., 2010).

ECEC research on children aged 3–6 years is fairly consistent, but evidence on the effects of earlier child care on the development of 0–3-year-olds is equivocal, with some studies finding negative effects, some none and some positive. Discrepant results relate to age of starting and probably to differences in the quality of child care. Child care impacts are also mediated by family background, with negative, neutral and positive effects depending on the relative balance of care quality at home and in child care. Recent large-scale studies (the Effective Pre-school and Primary Education project in United Kingdom (England) (Sylva et al., 2010) and the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) study of early child care and youth development (NICHD Early Child Care Research Network, 2005), for

example) find impacts related to quantity and quality of child care, with effect sizes for child care factors being about half that for family factors.

2.4 Research evidence for ECEC

2.4.1 ECEC 0–3 years

2.4.1.1 General population

The evidence for ECEC for 0–3-year-olds is not as uniformly consistent as it is for children over 3 years. It indicates that high-quality child care has no strong effects on cognitive and language development for children who are not disadvantaged in their home environment, but that poor-quality child care may produce deficits in language development (Melhuish et al., 1990). There is evidence to suggest that some forms of child care, particularly high-level group care in the first year of life, may slightly elevate the risk of developing antisocial behaviour.

2.4.1.2 Disadvantaged children

High-quality child care produces benefits for cognitive, language and social development; low-quality produces either no benefit or negative effects.

2.4.2 ECEC 3–6 years

2.4.2.1 General population

The evidence is consistent, showing that preschool provision for this age range is beneficial to educational and social development for the whole population. The effects are greater for high-quality provision.

2.4.2.2 Disadvantaged children

Disadvantaged children particularly benefit from high-quality preschool provision. Some evaluations of early years interventions have shown improvements in cognitive development, but these have persisted throughout children’s school careers in relatively few cases.

Early childhood interventions boost children’s confidence and social skills, which gives them a better foundation for success at school (and subsequently in the workplace). Research reviews imply that social skills and improved motivation lead to lower levels of special education and school failure and higher educational achievement in children exposed to early childhood development programmes. Studies into adulthood indicate that educational success is followed by increased success in employment and social integration and possibly in reduced criminality.

2.4.3 European evidence

Group settings for children typically from 3 years (sometimes younger) to the start of school (often 6) are common forms of provision in Europe. Some countries, including France, the Netherlands, Scandinavian countries and the United Kingdom, have made this kind of preschool provision universal and free, while others may provide free or paid-for services.

Evidence supporting the benefits of preschool is now very substantial (Melhuish, 2011). The Effective Pre-school and Primary Education project in United Kingdom (England) and the Effective Preschool Provision in Northern Ireland project provide particularly strong evidence of longer-term benefits for all children (see: Melhuish et al., 2008b; Sammons et al., 2008; Sylva et al., 2010; Melhuish, 2011). The powerful nature of this evidence has influenced policy in the United Kingdom, leading to universal free preschool education, and has also been increasingly influential in countries such as Australia, Norway and the Republic of Korea).

These longitudinal studies with very rich data from children have been supported by other forms of evidence from within Europe. Free preschool education was made available to children aged 3–6 years in France during the 1960s and 1970s, producing a huge increase in preschool attendance. Analysis of administrative data (Dumas & LeFranc, 2010) showed that preschool led to higher income in later life and reduced socioeconomic inequalities, with children from less-advantaged backgrounds benefiting more. Examination of the impact of expansion of preschool education in Switzerland (Bauer & Ripahn, 2009) found it had improved children's intergenerational education mobility and was especially beneficial for those from disadvantaged backgrounds. Research from Norway, which expanded preschool education for 3–6-year-olds during the 1970s, showed that preschool attenders had higher educational levels and better job outcomes later in life (Havnes & Mogstad, 2009).

The following section summarizes key features identified in the evidence showing how ECEC really makes a difference for children.

2.4.4 Quality matters

Research demonstrates that the following aspects of preschool quality are most important for enhancing children's development:

- responsive, affectionate and readily available adult–child interaction;
- well-trained staff who are committed to their work with children;
- safe and sanitary facilities that are accessible to parents;
- ratios and group sizes that allow staff to interact appropriately with children;
- supervision to maintain consistency;
- staff development to ensure continuity, stability and quality improvement;
- a developmentally appropriate curriculum with educational content; and
- parental involvement, particularly engagement that works to improve the home learning environment consistent with preschool activities.

Sweden's ECEC system is among the best in the world. Nordic countries have never felt the need to prove the importance of early years services: they just believe it is the right thing to do for young children and to promote gender equality. Sweden has developed a deeper interest in quality in recent years, however, with one study (Sheridan et al., 2009) finding great variation in the quality of ECEC provision as measured by instruments consistent with the above aspects of

quality. The variation was astonishing: 26% of preschools were of “excellent” quality, 23% “low” and the remaining 51% “good”. Even children under three years who attended “excellent” preschools were more successful in communication and language tasks and in early mathematics. The study concluded that children’s opportunities for learning depend on the quality of their preschool (Sheridan et al., 2009).

2.4.5 Cost–benefits of ECEC as an intervention

The results of the few cost–benefit analyses for ECEC as an intervention, where high-quality child care has been used for disadvantaged children, are unambiguous in showing substantial benefits. A striking feature is that the size of the benefits allows a very substantial margin of error within which interventions would still be economically worthwhile. Applicability of indications of savings to the general population is nevertheless open to considerable doubt. In that so much of the benefit in these They derive from studies of disadvantaged populations where benefits come from reductions of negative outcomes such as crime, remedial education and unemployment. The incidence of these negative outcomes is, of course, dramatically less in the general population, meaning scope for savings is similarly substantially reduced. In considering poor child outcomes, such as learning difficulties or behaviour problems, the “prevention paradox”, which holds that while the rate of incidence is greater for disadvantaged populations the absolute number of cases is greater in the general population, is nevertheless relevant.

2.4.6 Access to ECEC

ECEC participation rates in Europe have increased significantly over recent years. Those of 3-year-olds have risen by more than 10% since 2000: 74% of 3-year-olds, 87% of 4-year-olds and 93% of 5-year-olds in Europe attended a formal ECEC or primary education programme in 2006. While the problem of limited access has largely been solved for 5-year-olds, this is certainly not the case for the 0–3 group, or even for 3- and 4-year-olds in some countries.

Lack of supply is particularly acute in rural areas. The volume of provision for 0–3-year-olds seems insufficient in many European countries. Significant financial investment and the creation of new ECEC settings are needed. This could entail the development of a unitary ECEC system with settings that accommodate the entire 0–6 age group. The focus of most EU-level action has been on increasing the quantity of child care and pre-primary places to enable more parents, especially mothers, to join the labour market.

European Council Member States agreed in 2002 to provide full-day places in formal child care for at least 90% of children aged between 3 and compulsory school age, and to at least 33% of children under 3, by 2010. Progress has been uneven, as reported by the European Commission (2011):

For 0–3 year olds, five countries have exceeded the 33% target, and five others are approaching it, but the majority fall behind, with eight achieving only 10% or less. For the over 3 year olds, eight countries have exceeded the 90% target and three others are approaching it, but coverage is below 70% for one third of the Member States. In 2009, Education Ministers reinforced this

approach by setting a new European benchmark for at least 95% of children between age 4 and the start of compulsory education to participate in ECEC by 2020.

The need to extend coverage of preschool provision remains, but quality must be high. European countries have expressed a wish to cooperate more closely at EU level to increase ECEC quality. EU ministers stated in 2006 that ECEC can bring high rates of return over the life-cycle, especially for the disadvantaged. They agreed priorities for EU cooperation in 2008, including how to ensure accessible, high-quality preschool provision, and in 2009 adopted a strategic framework for cooperation to 2020 that included the priority of “promot[ing] generalised equitable access and reinforce[ing] the quality of the provision and teacher support in pre-primary education” (European Commission, 2011).

Unfortunately, data on ECEC participation rates for the European Region are not available for comparison. It is probably safe to assume that the picture is bleak, given that many of the public services widely available before 1991 have disappeared. Cultural issues, particularly in central Asian countries, have forced lower workforce participation for women, similar to the situation in some EU states, reducing demand ECEC to facilitate female employment. The case of Georgia, as set out in two United Nations Children’s Fund (UNICEF) reports (UNICEF, 2011; UNICEF & USAID Health System Strengthening Project, 2011), illustrates some of the problems in the European Region, but also the potential for governments to make a difference (UNICEF, 2011):

In Georgia, as in the South Caucasus region as a whole, participation in ECEC has been traditionally low. This is attributed to the inability of families to meet the cost of provision and a perception that provision – understood, presumably, as simply child-minding – was not necessary since there was always an adult at home to look after the child. The situation worsened in the immediate post-Soviet period, with enrolment falling from 45 to 23%. Since then, however, figures have recovered. Many problems remain, but the government has reorganized ECEC, devolving responsibility to the local level. A National Alliance on Early Childhood Development, established by the Health and Social Affairs Committee of the Parliament of Georgia, with the support of UNICEF, has led the development of a National Strategic Plan of Action for Early Childhood Development and formulated new Standards for Early Learning and Development of Children as a basis for the overall pre-school reform. There have also been developments in terms of the introduction of evidence-based programmes and the inclusion of disabled children in pre-school provision. Reviewing a range of such developments, UNICEF note, ‘a child born in Georgia 10 years ago was significantly worse off than a child born in Georgia today, particularly if that child was born into a poor family, a family from an ethnic minority, or a family living in a rural village. ... These successes have been possible due to government leadership, commitment and action, coupled with cooperation between civil society actors and support from the international community’.

2.5 What is done for disadvantaged children in Europe?

Early childhood is the stage in which education can most effectively influence children’s development and help reverse disadvantage. Research shows that poverty and family dysfunction

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have the strongest correlation with poor educational outcomes which, in turn, has a correlation with poor health in adulthood. Big differences in cognitive, social and emotional development already exist between children from rich and poor backgrounds at age three and the gap tends to widen by age five if not specifically addressed.

Most countries implement measures intended to prevent educational difficulties for children at risk. Intervention in most is targeted at groups on the basis of defined social, economic or cultural criteria, but support in a few is based on children's individual needs identified during the course of their education/instruction. Countries employ a variety of approaches that are not mutually exclusive, including:

- providing special language training programmes, mostly for enhancement of the second language but sometimes also for the mother tongue: these are most commonly compensatory programmes or provision of specialist support for older children (3–6-year-olds);
- appointing extra staff in mainstream settings that cater for all children but which also admit children with difficulties; and
- providing separate settings/sections for specific groups, such as children of the unemployed, refugees, Roma, ethnic minorities, children in particular circumstances (orphans, for example) or those separated from their family.

Three main strategies focus on providing additional financial support to ECEC settings for providing services to at-risk groups in Europe:

- additional financial assistance and/or additional staffing (the most widespread);
- financial incentives for staff working with children at risk or in settings where most children are from at-risk groups; and
- additional central-level financial support for local authorities to reflect regional demographic and socioeconomic factors.

Some countries have special regulations on staff ratios for groups that include children at risk, involving either an increase in the number of teaching staff (such as in Belgium and France, where these standards are integrated within a priority policy) or the addition of an assistant (as in Cyprus and Ireland). The numbers of children in class in Spain have been reduced. Standards in Slovenia vary according to the level of regional development or presence of Roma children, but measures usually apply to older children; only three countries (Bulgaria, Cyprus and Slovenia) set specific standards for children under 2–3 years and those at risk.

Evidence indicates that compared with pupils from native backgrounds, children of migrant families show a large overall gap in achievement levels. The performance of the second generation is lower than the first in many EU Member States, with rates of early school leaving on average twice as high. It should be noted, however, that ethnic minority groups can

outperform the native population in some countries (Chinese and Indian groups in the United Kingdom, for instance).

Migrant families are often unfamiliar with the language and education system of the host country, so supporting their children's learning can be challenging. There is strong evidence that participation in ECEC programmes can be highly beneficial for migrant children's cognitive and linguistic development. Model programmes in the United States have shown significant positive effects in terms of later educational success and income, and also in criminal behaviour. Providing early language assistance to children with a different first language is an important part of improving school-readiness and allowing them to start on an equal footing with peers.

Realizing ECEC's potential to address the inclusion challenges outlined above depends on the design and funding of the ECEC system. Evidence that universal access to quality ECEC is more beneficial than interventions targeted exclusively at vulnerable groups is clear. Targeting ECEC poses problems because it is difficult in practice to identify the target group reliably; it also tends to stigmatize its beneficiaries and can even lead to segregation at later stages of education. Targeted services are also more at risk of cancellation than universal.

It is important to bear in mind that ECEC and family support services, however good, can only compensate partially for family poverty and socioeconomic disadvantage. Increasing the long-term benefits of high-quality early childhood services for children from disadvantaged backgrounds requires links to initiatives in other policy areas through a comprehensive strategy that includes employment, housing, health and the benefits system.

2.6 Recommendations

As argued throughout this section, there is now substantial evidence not only on the importance of early years to better outcomes across the life-course but also in relation to what needs to be in place to ensure that all children get the best start in life. While most nations generally agree on the importance of education for children from around age 6, massive cultural differences in attitudes within and between countries about women working, time in child care and the role of fathers in caring for children remain. Basic features of a good system for children can be nevertheless be identified.

1. A universal, high-quality and affordable ECEC system is the essential bedrock in levelling vast social class differences in school attainment. High-quality ECEC systems are characterized by a clear developmental curriculum that blends child- and adult-led activities, well-trained staff who are sensitive to children's needs, reasonable flexibility in the hours the service is available to enable parents to work and, most importantly, affordability. An excellent system that is only available to better-off children will exacerbate rather than reduce class differences in outcomes.
2. 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 potential for postnatal depression. Quality care will also improve breastfeeding rates and help new mothers to link with available community support.

3. Some countries with excellent health and ECEC systems are less good at ensuring they work together. Service integration through co-location, sharing of data about families, joint budget arrangements or locality team arrangements helps to make services less fragmented for the end user and more efficient by reducing overlap of contacts and responsibilities.
4. Family support is essential, particularly for mothers and fathers who may find the experience of becoming a parent overwhelming. While poor parenting practices have a correlation with the class gradient, this is an issue for all families. The availability of informal culturally sensitive advice and support alongside more formal highly structured programmes will enable the targeting of more intensive support to families that are finding things difficult, while helping to reduce the possible stigma associated with acceptance of parenting support. A wide range of circumstances can affect parents' capacity to adequately nurture young children. Lone parents and those with mental health problems or physical disabilities need particular support, as do families with a chronically ill child.
5. 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, systems of social benefit supports (including cash transfers) and the myriad of other policy areas that can enable families to increase their income is required.
6. Where people live, work and access child care need to be aligned for policies to be effective. Housing and transport are particularly important in this context. Reducing health inequalities throughout the life-course will be greatly enhanced by reducing overall wealth inequalities. Families even in wealthier countries tend to be poorer when children are very young and more vulnerable to the impact of poverty.

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3. Later childhood

3.1 Setting the context

This chapter focuses on the period of childhood that extends from the end of the early years, through adolescence and on to the beginning of young adulthood.

Children's development and learning in the early years is shaped overwhelmingly in the context of the family. Not surprisingly, most efforts to improve and equalize outcomes therefore take the family as the unit of intervention, but the situation becomes more complex in later childhood and adolescence. The family continues to be of major importance, so most of the principles of family support set out in Chapter 2 hold good, but older children are much more clearly agents in their own development, taking decisions for themselves and building distinctive patterns of behaviour, attitudes and values. All of this has implications for the kinds of adults they will become and, specifically, for the health outcomes they will experience during later childhood and for the rest of their lives. This agency, as shall be shown, is a key factor for policy-makers and practitioners to recognize if they are to improve and equalize outcomes for this group.

Older children begin to engage with a range of contexts beyond the family, including their peer group, wider community and, above all, school. School is particularly significant because it constitutes a major state intervention in the lives and well-being of its future citizens. How well children do in school has a big influence on the kinds of adult lives they lead, the work they do and the material conditions under which they live – each of which has effects on their future health (Hammond, 2002; Cutler & Lleras-Muney, 2006; Feinstein et al., 2006). Schools play a significant part in helping children develop behaviours, attitudes and values, not least in relation to health and healthy (or unhealthy) behaviours. They also offer policy-makers and practitioners relatively easy access to children and young people, providing a setting in which health-related services, programmes and other interventions can be delivered. For all of these reasons, school education is given a prominent position in this chapter.

Policy-makers often tend to look to schools as the principal means of making a positive difference to children and young people, perhaps especially in countries where the reach of other services – including the health service – is limited, but where school education is more universally available. Health services even in affluent countries may find it difficult to access older children, while services perceived as non-essential, such as youth work, may have a tenuous existence and are always vulnerable to spending cuts. Children nevertheless spend far less time in school than out of it, and many young people leave education once statutory schooling is complete in their mid-to-late teens. It seems important, therefore, that policy and practice should not focus exclusively on school, but should also pay due attention to family, peer group and community contexts and to the child as agent.

A particular issue here is that the relative influence of these different contexts depends very much on service structure and cultural factors. It is not uncommon in northern and western

Europe, for instance, for children to experience a protracted adolescence, remaining in the nuclear family and continuing in education throughout the teenage years. This has not been the norm everywhere, however, and young people may have been expected to take on adult responsibilities by their mid-teens; even child labour is common in some places. These differences have important implications for how policies are targeted towards older children. Equally important is the fact that migration and globalization processes create complex patterns in many countries, with different cultural practices existing side by side within the same administration.

3.2 The state of the art

3.2.1 Overall well-being

What children do in later childhood is important for its own sake, but it is also the period in which the nature of an individual's adult life begins to take shape. Young people acquire skills, knowledge, attitudes, values and behaviours in this period that will substantially influence how they live the rest of their lives, the kinds of people they will be and the opportunities that will be open to them. Many long-term outcomes are shaped significantly by what happens to children in the early years, but they are usually not fixed; important changes can occur in later childhood (Gutman et al., 2010). The principle of early intervention, in the sense of intervening while outcomes are still malleable, therefore applies as much to older children as to those who are very young.

Much is already known about the conditions required for good outcomes in this period, the basic reasons for poor implementation, approaches recommended for equalizing outcomes and the evidence to support them (see Dyson & Jones (2011)). General availability of nurturant environments is of paramount importance for developing socioemotional and cognitive skills, which in turn grant young people the capacity to make informed decisions about their own health. Families' capacity to provide a supportive home environment is crucial, therefore, but so too is the availability of good-quality schools and safe environments and outdoor spaces in which young people can develop through play and social interaction.

The extent to which these environments are available is likely to be related in complex ways to the socioeconomic circumstances in which children live. The relationship between background, environment and outcomes is by no means deterministic, but children from poorer backgrounds are likelier than their more-affluent peers to experience ineffective parenting, attend inadequate schools and live in unsafe environments, consequently experiencing poor outcomes (Duckworth, 2008; Griggs & Walker, 2008). Among other things, a home environment conducive to positive development is hard to establish and maintain in the face of family poverty, hardship and disadvantage, while social inequalities see the emergence of socially segregated schools that maintain the problem. It follows that tackling socioeconomic inequalities – and, specifically, tackling child poverty – is a key strategy for equalizing outcomes (Ballas et al., 2012). In particular, giving parents access to good-quality employment opportunities is often seen as the

best route out of childhood poverty. Not all inequalities of experience and outcome are related straightforwardly to socioeconomic circumstances, however. Difficulties for children may also arise from insensitivity and discrimination in relation to gender, cultural identity and language backgrounds. Difficulties in communicating with this particular age group can also result in poor outcomes.

Government policy has a key role to play in creating the conditions under which children can flourish. Although they must necessarily act within the constraints of regional and global economic circumstances, governments can take actions that increase or decrease levels of socioeconomic inequality (Dyson et al., 2012). More affluent countries tend to generate better outcomes for children, but international comparisons suggest that those with similar levels of wealth generate very different levels of well-being for their children, and that this is related significantly to the kinds of policy regimes they develop (UNICEF, 2007). Good outcomes are possible even in poorer countries if the quality and focus of public and voluntary services is appropriate (Balabanova et al., 2011).

Schools can play a key part by working directly with children, promoting their development and increasing opportunities available to them as adults, but they and other child and family services can also assist in improving conditions within the home and implementing policy to encourage and support parents in their parenting strategies. Such support often takes the form of parenting programmes or advisers. Support is required from a range of services, with increasing demand for integrated service delivery and alliances between sectors. Approaches are also being developed in partnership with families to achieve projects that are tailored to the needs of their intended recipients, with area-based initiatives being utilized for public spending so that those living in the most disadvantaged areas can be reached. This is discussed in more detail below.

The evidence for approaches like those mentioned above is usually best considered in relation to specific examples and will be considered in practice in this chapter. At a very basic level, however, it has been observed that the best outcomes for child well-being are finance-related, with optimum outcomes emerging from countries with the lowest levels of relative poverty, such as the Nordic countries (Pickett & Wilkinson, 2007; UNICEF, 2007).

3.2.2 Educational outcomes

Much is known about how to generate good educational outcomes and tackle educational inequalities. An international evidence base on what is usually known as school effectiveness (Teddlie & Reynolds, 2000; Townsend, 2007) exists, and OECD (chiefly through analyses of Programme for International Student Assessment (PISA) data) have developed principles for system effectiveness (see, for instance, OECD (2010)). European countries have contributed to this knowledge substantially, though it is worth noting that much of what is known comes from more-affluent parts, particularly the north and west.

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A broad distinction can be made between achieving adequacy and striving for excellence in relation to improving outcomes. The former is about ensuring enough school places, trained teachers, resources, materials and buildings of reasonable quality. These are of considerable significance globally, and the United Nations Educational, Scientific and Cultural Organization (UNESCO) “Education for all” movement (UNESCO, 2013) has done much to identify what needs to be achieved in these respects. Essentially, however, provision adequacy depends on countries’ ability to avoid chronic poverty, coupled with a political will to direct resources to education and ensure that education is available to all on something like an equal basis.

Excellence is about moving beyond basic education provision to concerns about its quality and, more particularly, ensuring that the education system produces young people with the skills and knowledge to enable them (and their country) to compete in a globalized economy and labour market. The essence of the extensive and rapidly evolving knowledge base on this issue seems to be a combination of:

- opportunity, which is about extending children’s and young people’s time spent on learning activities during the school day and year and engaging in education throughout the teenage years into what is sometimes called lifelong learning;
- quality, relating to ensuring that opportunities are as rich as possible through being delivered by well-trained teachers using effective pedagogical techniques in well-organized and well-led schools; and
- alignment, ensuring that all aspects of the school system work together to enhance children’s learning so that curricular aims are clear, assessment procedures match the aims, teachers and schools have incentives to perform highly in achieving the aims and different phases of the system act in a coordinated way.

The issue of overall quality, however, has to be considered alongside that of educational equity (OECD, 2012). A case can be made that educational outcomes can never be entirely equal, but it is clear that inequalities in outcomes in every education system relate to social differences. So, for instance:

- girls and boys may achieve different outcomes
- children from different parts of the country may perform differently
- children from poor, migrant or ethnic minority families may do particularly badly.

These patterns tend to be complex and to vary from country to country. In some instances, it is simply a case of unequal distribution of opportunities (good-quality schools are not universally available, for instance, or the education of one gender is valued less than that of the other). In other cases, however, opportunities are notionally available, but some interaction between their nature and social groups’ cultural characteristics means they are not taken up equally. It is worth noting that these issues are by no means confined to poorer countries and that instead of freeing children from the disadvantages in their backgrounds, education may simply confirm or even

compound them. This can mean that education does nothing to reduce the health-risk factors to which the most disadvantaged groups are subject, ensuring they continue to remain vulnerable.

Educational equity has been a significant concern for many countries and transnational organizations. Data availability, particularly in better resourced systems, is almost certainly a factor; as countries have begun to monitor system performance more carefully, they have also become aware of which learners are falling behind.

The evidence base on how countries can respond to educational inequity is now substantial. As with overall quality, it is useful to make a broad distinction between two kinds of strategy (though there are significant overlaps). One seeks to address inequalities of opportunity, focusing on ensuring that basic educational opportunities are genuinely available to all and taking steps to ensure that learners can and do take advantage of them. UNESCO has taken the lead through its initiative on inclusive education (see, for instance, UNESCO (2009)).

Its strategy (strongly influenced by difficulties experienced by disabled children in many parts of the world in gaining access to education) has been to argue that schools and education systems should strive not only for basic adequacy, but also for responsiveness to learners' diverse characteristics and backgrounds. Countries can maximize the likelihood that learners from diverse backgrounds will access educational opportunities by developing schools that are not only adequate, but also inclusive. Inclusion in this sense remains an issue even in the best-resourced education systems, but in this instance, it is more likely to interact with education systems' failure to enable all learners to achieve similarly high outcomes.

A second set of strategies has emerged in these contexts. In very broad terms, these take the form of ensuring that learners receive adequate support to overcome learning, psychological and social barriers that restrict their achievements and ensuring that education system structures do not create barriers of their own. OECD has set out "10 steps to equity" that usefully capture the state of knowledge in this field. The first four focus on design:

1. limit early tracking and streaming and postpone academic selection;
2. manage school choice to contain risks to equity;
3. provide attractive alternatives in upper secondary education, remove "dead ends" and prevent dropout; and
4. offer second chances to gain from education.

The next grouping relates to practices:

5. identify and provide systematic help to those who fall behind at school and reduce year repetition;
6. strengthen links between school and home to support disadvantaged parents to help their children to learn; and

7. respond to diversity and provide for successful inclusion of migrants and minorities within mainstream education.

The remainder focus on resourcing:

8. provide strong education for all, giving priority to early childhood provision and basic schooling;
9. direct resources to students with the greatest needs; and
10. set concrete targets for more equity, particularly related to low school attainment and dropouts (OECD, 2008).

The close association between educational inequalities and wider social inequalities nevertheless underpins many equity issues in education. Put simply, learners from socioeconomically marginalized and disadvantaged groups are likely to have access to fewer educational opportunities and to be less able to take advantage of those they have. Education systems therefore tend to reflect (more or less strongly) existing hierarchies of advantage and disadvantage in societies; a plethora of priority policies across European countries appears to have done relatively little to change this situation (Demeuse et al., 2012). The sociologist Basil Bernstein's famous formulation is that "education cannot compensate for society" (Bernstein, 1970). While this assessment may now be regarded as perhaps too bleak, there is little doubt that strategies to promote educational equity need to be closely aligned with more wide-ranging initiatives to promote social justice and equality.

This is important for the relationship between education and health. The social determinants of health outcomes are often also the social determinants of educational outcomes. It follows that efforts targeted at improving and equalizing one set are likely to affect the other. The implication is that a joined-up strategy to address both simultaneously is necessary and possible.

3.3 The European context

Many issues relating to later childhood that arise in other regions can also be found in Europe. This section reviews features of the European situation that deserve particular attention.

One such issue relates to inequalities between countries. The European Region is relatively affluent and stable in global terms, but significant differences exist between countries, with implications for services and the outcomes children achieve. The east and south of the Region, where countries tend to be poorer and services struggle with reorientation consequent to political transformation (UNICEF Regional Office for Eastern Europe, Central and Eastern Europe and Commonwealth of Independent States, 2011), face particular issues, but inequalities of outcome are not necessarily related to wealth and political stability in any straightforward way, provided an adequate level of services is available. As UNICEF has noted, it is certainly not the case that

children and young people from rich European countries do better than those from their mid-ranking neighbours (UNICEF, 2007).

Substantial inequalities in outcomes for children and young people exist within many European countries (Ballas et al., 2012). Economic difficulties and state withdrawal from service provision in southeastern Europe, for instance, are considered to have increased polarization of educational opportunities and outcomes (Motivans, 2000). Stable and affluent countries also generate inequalities, however: while the end of compulsory schooling sees most young people enhancing their life chances by moving on to other forms of learning or employment, a rising number in United Kingdom (England) – over 16% of 16–24-year-olds – do no such thing (Department for Education and Skills, 2011).

Inequalities among young people in Europe are particularly associated with patterns of migration. The affluence of many countries makes them a magnet for migration, particularly for people from less-affluent neighbouring states (Eurostat, 2011). This has implications for children who migrate with their parents and who can find themselves uprooted, receiving inadequate services and relatively isolated in their host countries. Children who stay behind in their home countries may find themselves separated from their families and cared for by members of extended families who may or may not be able to offer them an effective and nurturant home environment. Some migrant children find themselves marginalized and discriminated against within a wider pattern of discrimination on the grounds of race and ethnicity in European countries, with discrimination and poor outcomes endemic for Roma children (Roma Education Fund, 2010).

3.4 Promising strategies in Europe

This section outlines some strategies used in European countries to improve and equalize childhood outcomes. They are drawn principally from the case studies commissioned for this report, supplemented by some that have been published elsewhere and by the task group's knowledge of the field.

The examples exemplify and contextualize some general principles outlined above, but a word of caution is necessary. Some approaches to improving outcomes are more likely to find their way into case studies than others. These very often take the form of discrete initiatives that may be supported by additional funding, rather than more gradual, less dramatic policy and practice developments. It is not certain, however, that “eye-catching” initiatives alone are what is needed: this point is addressed in the conclusions.

Similarly, not all initiatives (however effective they seem) have been rigorously evaluated. Many European Region countries participate in the Health Behaviour in School-aged Children (HBSC) WHO collaborative cross-national study, in which data on a wide range of health and social indicators are gathered every four years from 11-, 13- and 15-year-olds (Currie et al., 2012; Currie et al., 2011), but monitoring data tend to be sparse, especially for children younger and

older than the HBSC age band, and evaluation evidence is a significant problem. Strategies reported below are therefore more often promising than proven.

The final caveat is that efforts in this field tend to focus on overall improvements to, rather than equalizing of, outcomes. It is reasonable to assume that overall improvements may lift outcomes for those at the bottom of any distribution to an acceptable level, but there is no reason to believe that they alone will reduce inequalities and, indeed, may even increase them if those who are already doing well benefit disproportionately. More targeted strategies may therefore be necessary, alongside work on systemic improvement.

3.4.1 Coordinated health action programmes

Cross-sectoral approaches are difficult to formulate even in the early years, when different aspects of children's development arguably remain closely related and a health-led perspective makes a great deal of sense. Problems become even more acute as children grow older and as the services they use develop differing agendas. It is therefore difficult to find fully integrated approaches to development in later childhood, but examples of coordinated action on a more limited basis exist. Those involving schools are addressed below, but there are also examples of strategic approaches to identified health issues affecting young people. Examples come from Armenia (Box 3.1) and France (Box 3.2).

Armenia and France differ significantly in terms of history, institutions and wealth, but the approaches outlined in Boxes 3.1 and 3.2 have some important common features:

- a strategic approach with leadership at national level;
- identification of clear priorities, perhaps supported by quantifiable targets;
- collection of data to increase understanding of the issue and assess progress;
- mobilization of a range of resources at all levels of the health system; and
- use of school as the primary context for intervention but an (emerging) understanding of other contexts in which young people live that are likely to shape their attitudes and which should therefore be targeted for interventions.

It is worth noting that strategies of this kind tend to focus on identified health issues rather than on health or other inequalities per se: any impact on inequalities therefore depends on the extent to which the prevalence of these issues is distributed unequally across the population (countries with good data can check this). There is also considerable potential for these strategies to be tailored towards the most vulnerable groups of children.

The Armenian and French strategies are relatively low cost in that they involve making the most of existing resources rather than creating new services and structures. In both cases, however, the strategies' reach was initially somewhat limited. There is clearly a need, therefore, for strategies to learn from experience and develop over time so that data collection is not just about monitoring progress, but is also about creating a feedback loop for strategy development.

Box 3.1. Armenia case example

Collaboration involving the Ministry of Health, UNICEF, nongovernmental organizations (NGOs) and professional institutions saw the development in 2005 of the national concept on youth-friendly health services and subsequent emergence of a national strategy on child and adolescent health. Activities such as staff training using WHO orientation programmes, development of national standards of care and approval of standards in some pilot districts were taken forward.

The national strategy identified a set of aims for development and surveillance of adolescent health, with implementation beginning with compulsory health status screening of girls at 12 and boys at 15, initiated by the Ministry of Health. Nurses were given specific training and adolescent health was introduced to under- and postgraduate health curricula.

Barriers to implementation revolved around time and resources. Screening was considered to offer insufficient analysis in some cases, with a lack of time and training in counselling skills among doctors and nurses leading to inadequate consultations. The vast majority of family doctors are women, which proved a disincentive for boys to seek consultations.

The family setting is not straightforward as a result of socioeconomic inequities and inadequate resources, but the traditional family structure has the potential to offer greater support and better communication than those of other European countries, with high priority being placed on improvement of communication problems within the home. It is suggested within the case study that the Armenian family has not yet adapted to adolescents' needs because the concept of adolescence has only recently been created in the country as a product of the independence era and free-market generation. School therefore still appears to be the key arena for implementing change, as a high proportion of Armenian children and adolescents claim to like school.

A particular issue is the extent to which strategies of this kind rely on activating parts of the health care system, perhaps with some additional interventions in schools, as opposed to involving a wider range of social agencies. Although the targeted outcomes of strategies may lie clearly in the health field, non-health agencies may need to be involved to tackle the social determinants of those outcomes. An interesting example in this respect is a strategy in Hungary to tackle injury prevention among children and young people (Box 3.3).

As with the French and Armenian strategies, the impact of this approach on health inequalities (as opposed to overall health outcomes) will depend on how the five priority issues affect different social groups. It appears to be difficult to evaluate programme implementation, which is common with strategies of this kind.

The HBSC survey is a prime source of data in Hungary, as in many countries, but while it is good for analysing medically-treated unintentional injuries, the most serious accidents are

unrepresented, as the survey is completed within schools. National data nevertheless suggest a reduction in morbidity and mortality associated with unintentional injuries has been achieved, which qualifies as the most convincing evidence at present, but this result cannot be attributed to the influences of a specific programme or intervention.

Box 3.2. France case example (1)

Concerns have been raised in France, as in many affluent countries, about health problems related to poor nutrition and lack of physical activity among children and young people.

A dual action plan was implemented as part of a national nutritional health programme (Programme National Nutrition-Santé (PNNS)) to decrease obesity prevalence among young people.

Nutritional prevention measures were set up for the whole population and specific subgroups, and screening of children for nutritional problems and obesity management during school medical examinations was improved. A multidisciplinary obesity management approach was recommended with the cooperation of medical and non-medical professionals.

The first national health programme was implemented in January 2001, with the overall objective of improving the health of the general population through action on nutrition as a major determinant. Within this, nine quantified priority objectives relating to food consumption, physical activity and biological and anthropometric indicators were established.

These were promoted by the Ministry of Health within public and private sectors through training, research and monitoring. The project's main objectives were to halt the increasing prevalence of obesity among young people and improve children's and adolescents' calcium and vitamin D status and infants' iron status.

A national food guide based on PNNS objectives was created in 2002, initially aimed at the general population but later adapted for parents, health professionals and adolescents. This strategy enabled adolescents to base their nutritional intake on personal preferences and enjoyment of food, while highlighting the significance of their eating choices.

A PNNS logo was created for all signature campaigns, but nongovernmental bodies could also apply to use it. The logo has subsequently been used to validate several scientific- and educational criteria-based nutrition education tools from associations and catering companies, but few initiatives target collective responsibility in areas such as food supply and changes in environment. PNNS has now been developed into PNNS2, with aspirations to implement actions in these areas.

School is an important setting for implementation and a key influencing factor, but adolescents spend only a limited amount of time there. While evidence for approaches outside the school setting is still being accumulated, implementing nutrition-based goals within alternative settings such as family and leisure environments may have greater effects on diet and physical activity levels.

Box 3.3. Hungary case example

Unintentional injuries are the leading cause of death among children and young people aged 1–19 in Hungary and also commonly result in permanent disabilities. The Hungarian government has endorsed three major policy documents affecting child injury and prevention policy. The first is the national programme for infant and child health (Ministry of Health, 2005), which is based on an understanding that adults' physical and mental abilities and their subsequent capacity to avoid disease and maintain health are rooted in their childhood experiences. This particularly holds for injuries. A national injury prevention strategy was developed with the programme, stressing the risks to which young people are exposed and proposing means of prevention. A road and safety action plan that focuses on risk reduction for children while travelling was also developed subsequently.

The second is the national child and youth safety action plan, implemented in 2010 by the National Institute of Child Health. This aims to reduce mortality from unintentional injuries by 30% in 10 years. It brought 18 experts from various fields and social sectors together to identify five critical issues: road traffic safety; home safety; safety in care institutions; play, leisure and sports; and coordination, evaluation and monitoring. Expert working groups were then assigned to each critical issue.

The National Institute of Transport Sciences has made changes to licensing laws for young drivers, including zero alcohol tolerance, the aggregation of a demerit point system and measures to enforce car owners' responsibilities. NGOs have set up "rules of the road" practice parks in which pedestrian and cyclist traffic skills can be practised with trainers. Mobile versions of these parks have been established for rural areas. The home safety programme has used televised spots to disseminate safety messages and employs web sites for interactive learning, with simpler communication strategies being tailored for different age groups and physical and mental ability levels. Health professional education for those working with children with different needs has also been a key element and a burns and scalds prevention programme for children aged 10–14 years was established in the Bethesda Hospital.

The play, leisure and sports safety aspect is managed partly by the National Authority of Consumer Protection. A drawing competition focusing on safety creates awareness, with submitted images being used to compile a widely-distributed calendar. The paediatric clinics of University Pécs published a report on how to "have fun and be safe" for schoolchildren in support of a media campaign for bicycle helmet use. The final coordination, monitoring and evaluation element sees intersectoral coordination ensured by a body from the International Child Safety Committee, led by the National Institute of Child Health.

Differing settlement size poses a barrier to implementation of many programmes. While small towns may be safer, they frequently have insufficient educational services and other amenities; larger cities provide greater facilities, but have a more heterogeneous population that creates more varied problems. Implemented programmes therefore face the challenge of making themselves appropriate to the needs of the populations they deal with.

3.4.2 Using data

The case examples in Boxes 3.1–3.3 show that efforts to improve and equalize outcomes for children and young people depend heavily on the availability of good-quality data. Good data make it possible to:

- identify outcomes (particularly health outcomes) that are problematic and require action;
- explore possible explanations of why these outcomes are problematic and analyse interconnections between outcomes, which is particularly important in a social determinants approach;
- identify groups of children and young people who are particularly vulnerable to poor outcomes, the places they live and the services to which they have access so that efficient and effective targeting is possible and an attack on inequalities can be mounted;
- monitor strategies' implementation and impacts; and
- create a feedback loop to inform further strategy development.

Countries in Europe, and sectors within countries, are at very different points in data generation. It is relatively straightforward to collect basic data where children have contact with universal services: data collection and analysis in these services has become very sophisticated in some countries, a good example being the comprehensive and detailed data on school outcomes available in United Kingdom (England), but it is often difficult to combine services' databases and extremely challenging to track outcomes that are not the sole and immediate responsibility of any one service. Effort may be necessary in these circumstances to formulate a data collection strategy. An example from Ireland (Box 3.4) illustrates what may be involved.

The question of what counts as data is rising in relation to developing data strategies. Quantitative administrative data tend to predominate (for good reasons), but the picture they provide is inevitably somewhat unidimensional; it is interesting that the Irish data strategy also values children's views.

Other countries have similar strategies for collecting survey data on children and young people's lives: Germany, for instance, has instituted the Studie zur Gesundheit von Kindern und Jugendlichen in Deutschland (National Health Interview and Examination Survey for Children and Adolescents) (Robert Koch Institut, 2005), widely known as KIGGS, which surveys a sample of children between 0 and 17 years and is supplemented by a series of targeted modules in areas such as mental health.

3.4.3 School-based health programmes

Many strategic approaches to improving and equalizing health outcomes use school as a convenient site for intervention. Some countries have gone a step further by coordinating the wide range of opportunities and resources located in schools into a coherent effort to improve short- and long-term outcomes, representing a more strategic approach developed particularly

within the framework of (or inspired by) the Schools for Health in Europe¹ (SHE) network (Schools for Health in Europe, 2013).

Box 3.4. Ireland case example

The Irish case study examines the development and use of a set of children’s well-being indicators within the national children’s strategy. The strategy was published in 2000 as an initiative of the United Nations Convention on the Rights of the Child (United Nations, 1989), proposing a ten-year action plan that would move the country towards a state of greater respect for children and their voice and contribution to society and support them in pursuing their right to enjoy safe, full childhoods. Collaboration between professionals and young people was fundamental to the plan, ensuring the project was child-centred, equitable and inclusive.

The National Children’s Office was established to lead implementation, a key part of which was the formation of the National Children’s Parliament, a forum in which children can debate issues that concern them. A Children’s Ombudsman was appointed to liaise with children and promote their welfare and rights through addressing complaints raised. The ombudsman publishes an annual report.

The dominant theme of the strategy is better understanding of children’s lives and experiences. Child well-being indicators were established to progress this theme through two empirical studies. The first saw children being given tasks to identify what they viewed as important in ensuring they were well and stayed well, with an overall schemata being formed after the study had undergone several phases with different groups of children. The second involved a group of key informants made up of parents, policy-makers, researchers and service providers who collaborated to determine a final set of indicators from those the children of the first study had identified. The final set of indicators was then divided into six domains: sociodemographic; children’s relationships; education outcomes; health outcomes; social, emotional and behavioural outcomes; and formal and informal support. This initial report therefore set a benchmark for the development of children’s well-being and development in Ireland.

Three subsequent reports have been released, allowing trends to be observed. Progress reports in 2002, 2003, 2004 and 2005 indicated substantial progression in the three main goals identified in the initial report, with all intended activities addressed by 2005.

Proof of the success of this intervention can be deduced from the presence of the child well-being indicators, which are publically available for use in monitoring, describing and evaluating the state of children in Ireland. The “state of the nation’s children” report series also helped to identify specific issues within children’s lives, such as binge drinking. Findings such as this have in turn facilitated national consultations with young people about alcohol misuse – a problem that may have gone unnoticed in the absence of regular publication of new data.

¹ Previously known as the European Network of Health Promoting Schools (ENHPS).

Although there are some variations and indicators (Barnekow et al., 2006), a health promoting schools approach is always founded on the principles of pupil participation and a whole-school focus, explicitly addressing inequality by aiming to ensure schools are learning communities in which all feel trusted and respected (see Clift & Jensen (2005) for an evaluation). “Shape-up”, a programme focusing on overweight and obesity in children and young people that has been implemented in countries across the EU, is an example of this approach in action (Box 3.5).

Box 3.5. “Shape-up” case example

Core funding for “Shape-up” was provided by the European Commission Directorate-General for Health and Consumer Affairs. Local authorities and schools from 19 cities in 19 EU countries participated, with children and young people between 4 and 16 years taking part.

The fundamental premise was that healthier eating and regular physical activity are key to preventing childhood obesity and promoting children’s and young people’s health and well-being, and that healthy diet and physical activity are influenced in more efficient and sustainable ways by addressing their determinants at school, family, community and broader societal levels, rather than solely focusing on individual behaviour.

“Shape-up” paralleled national strategies described in Boxes 3.1–3.4 in that it sought to activate a range of agencies in pursuit of its strategic goals. Each participating city had a local promoting group consisting of local professionals and policy-makers to coordinate action across arenas. This cross-sectoral approach encouraged links among schools, communities and community agencies. Involvement of children and young people (through their schools) in investigating the social determinants of obesity and formulating proposals for action to address them was key.

The IVAC (investigation, vision, action and change) approach was used as a guiding framework to support children in taking concrete actions to improve the determinants underpinning their health. Typically, this meant improving the quality of food on offer in school, enhancing opportunities for physical activity in school and in community settings, and increasing parents’ understanding of health issues. The relationship between schools and the local promoting group provided young people with the capacity to see their ideas turned into action, with developments promoted by the programme supported by changes in policy and infrastructure at local level.

The project did not focus on tackling inequality per se, but demonstrates that children and young people are able to initiate processes that improve determinants in their local environment and thereby promote the health of all children.

The IVAC approach used in “Shape up” has also proven effective in a weight-reduction programme in a less-resourced area in northern Spain (Llargues et al., 2011), where it seemed to be more effective for pupils with well-educated parents than for those whose parents were educated to primary level or less or those with an obese mother. The project found that

participatory and action-oriented approaches work to improve health in deprived areas and that a more intense and adapted approach is needed to support children whose parents have low education levels.

In its original form, “Shape-up” required additional funding and a Europe-wide supportive infrastructure, but the principles it embodies are not expensive and seem likely to produce sustainable change. The essence is energizing and coordinating existing resources and, in particular, capitalizing on the power of the school to intervene and educate in health matters. Involving children and young people and recognizing them as agents in their own health means that the approach has in-built sustainability, with changes in understanding being likely to be carried forward into adulthood. In this respect, it is important to note that the SHE network is by no means restricted to the more-affluent countries of northern and western Europe.

School-based programmes of this kind can be used as a means of working with a wide range of children on health issues, but the basic methodology is flexible. It can be targeted at children who are deemed for some reason to be at particular risk and can be used to address a wide range of social determinants of health and presenting health problems.

A central steer on interventions may be necessary, but a good deal of the decision-making can be left to schools and other local actors, meaning actions match local needs and inequalities. In this way, it has the potential to play an important role in tackling health inequalities. Some examples of how this can be achieved come from Cyprus, Denmark and France (Boxes 3.6–3.8).

Box 3.6. Cyprus case example

The Health Education Office sends a circular each year to directors of elementary, secondary and technical schools inviting applications for funding to support health promotion programmes, encouraging involvement of a wide range of approaches rather than simply traditional forms of health education.

Schools are expected to embed their proposals within their action plans on health education, involve community groups and organizations and bring about sustainable changes to the school environment, children, teaching staff or community.

Funding is available only for schools in zones of educational priority (that is, those serving disadvantaged populations) or for projects targeting high-risk groups. While funding is for health promotion, any activities that address social determinants are considered.

Some projects, for instance, fund activities out of normal school hours for children living in deprived areas or who display difficult behaviours or are otherwise at risk. These are intended to give children a safe place and promote their personal development. Activities with parents have also been supported, with parents playing a role in deciding the activities they would like to be able to access.

Box 3.7. Denmark case example

Pupils from ethnic backgrounds other than Danish in a deprived area of Copenhagen were invited to become actively involved in developing a new school canteen. The project focused on many dimensions, including food quality, preparation and preferences and the canteen's aesthetic qualities. The new canteen now offers four meals daily, with children participating in the kitchen (in collaboration with trained professionals) as part of their home economics classes. Meals are partially paid by parents, but families with three or more siblings receive a discount and a free school meal entitlement scheme is available for those who are especially disadvantaged. The municipality partly finances the operation of the initiative and production kitchen running costs.

The project has improved healthy eating among students and boosted social capital at the school. It demonstrates the importance of pupil participation in developing their sense of ownership and improving their health.

Box 3.8. France case example (2)

"Learning to live better together", a school health promotion programme focusing on social climate, was implemented in 115 primary schools across 6 regions. The aim was to develop sustainable health promotion projects in the school setting through empowering local actors, employing a comprehensive approach that covered teaching, social and physical environment and links with families and community.

Pupils were stratified in four different privilege categories in the evaluation, with the programme being found to diminish inequity among students in relation to specific outcomes. The overall conclusion was that schools can contribute to reducing the health divide but should not be considered as the magic bullet. Empowering actors and building stronger links among schools, families and local communities are therefore important elements in reducing the gradient of health inequities.

The programme recommended that the following dimensions be in place to ensure the approach's effectiveness:

- a comprehensive approach
- an approach deeply rooted in the educational culture of the country/region
- empowerment of a wide group of local actors
- a sustainable long-term policy.

The case examples in Boxes 3.6–3.8 focus on groups of children and young people who are particularly vulnerable to poor outcomes, which is particularly interesting from a health inequalities perspective. Working through schools is advantageous because learners from

particular social groups tend, in most countries, to congregate in particular schools, either because the schools serve disadvantaged areas or because learners are selected into them. Schools are in a position to know a good deal about their students and their backgrounds, making targeting possible. There are also dangers in this approach, however. By no means all disadvantaged children go to schools in disadvantaged areas, while schools' knowledge of their students may be based on impressions rather than evidence. In addition, the most vulnerable children may simply not be in school: early school leaving is a problem even in the more affluent parts of Europe (European Commission, 2011) and being out of school is a significant risk for some marginalized groups in the poorer parts of the Region (UNESCO, 2010).

While school-focused interventions alone can never be enough, there would appear to be something to be said for at least some targeting through schools, provided it is well managed and is set in the context of more universal strategies.

3.4.4 Extending schools' roles

School-based programmes of this kind can simply be a matter of using schools as a convenient site for the delivery of health-related programmes. It is also possible, however, to take a more holistic view in which the promotion of health and educational outcomes are seen as deeply interconnected. This is the case, for instance, in the *Anschub.de* programme in Germany (Paulus, 2009). *Anschub.de* shares many of the features of health promoting schools initiatives elsewhere in Europe but lays particular emphasis on synergies between school strategies that promote good health and those which create a good school academically and in other respects. It also emphasizes the importance of multisectoral support for schools and of the involvement of pupils, parents and community-based NGOs in school development.

It is a short step from programmes of this kind to a more fundamental rethinking of the role of schools. Schools' core business is and always has been the promotion of academic achievements among their students, but it is also possible for them to become active in many more aspects of children's lives and, indeed, in the lives of families and the communities in which children live.

An international movement of what are sometimes known as full-service or community schools is developing. In addition to academic work, these also offer services and opportunities to students, families and community members that are not restricted either to education or to health interventions. Many European countries have schools of this kind. The OECD, for example, has reported a wide range of initiatives in Europe and elsewhere linking schools and community services (OECD, 1998a); *brede scholen* (broad schools) offering a range of services in the Netherlands, with similar initiatives in Belgium; Swedish schools offering services to children over and above teaching, such as counselling, study support and leisure activities; and efforts to link schools and communities, usually sponsored by NGOs, in parts of eastern Europe. Recent initiatives in the United Kingdom – particularly in England – have, however, been among the most ambitious anywhere in the world (Box 3.9).

Box 3.9. United Kingdom (England) case example

Every state school was expected to offer access to a range of extended services, including out-of-hours activities, learning and child care, family support, adult education, community access to school facilities and close partnership with specialist services such as health and social care, by 2010. They are sometimes offered on an open-access basis but are often targeted at children and adults at particular risk, with schools serving deprived communities commonly offering the richest array of services.

Typically, groups of schools work together to offer services in partnership with other community groups and agencies. Although schools have considerable flexibility in deciding what is needed in their areas, their decisions form part of local strategies for providing services and tackling disadvantage. These in turn have been part of a set of national strategies for promoting children's well-being and reducing social exclusion.

In practice, schools address a wide range of issues through their services. Improving educational attainments overall and/or narrowing the attainment gap between their lowest-performing students and the rest are important issues for them, but they also tackle children's personal and family difficulties, including specific health issues such as teenage pregnancy or obesity. Schools very often see extended services as closely related to their efforts to become a health promoting school, but some also use their services to increase the life chances of people living locally, tackle interethnic tensions in local communities or contribute to economic regeneration in areas they serve.

These initiatives have been extensively evaluated (see Cummings et al. (2011) for an overview) with positive findings. Significant impacts on educational and other outcomes (including health outcomes) for children and adults at greatest risk have been seen, but the evidence for effects on overall levels of attainment is less convincing, as is that on whether schools can make a real long-term difference to the areas they serve.

3.4.5 Priority policies in education

Although full-service schools and their equivalents tend to have wide-ranging aims, in educational terms they form part of a battery of interventions intended to narrow the gap in achievement between more- and less-advantaged groups of students. These interventions – sometimes known as priority policies – typically take the form of targeting additional resources at points of greatest need.

This can be done by targeting individuals – most education systems, for instance, have special needs provision targeted at students with disabilities and other difficulties. It is also possible to target particular groups (such as migrant children) or low-performing schools. The zones of educational priority mentioned in the Cyprus case example (Box 3.6) (there have been similar policies in France, Portugal and United Kingdom (England)) provide an example of targeting

geographic areas in which deprived populations are concentrated. Additional resources in these initiatives usually arise as part of a package that might include specification of teaching approaches and other strategies, encouragement of local innovation and intensification of monitoring and target-setting.

Priority policies of this kind take many different forms. Those targeting Roma children in some countries form a particularly interesting group, not least because Roma children tend to do especially poorly in many education systems and because their educational difficulties are linked to many other aspects of marginalization, including poor health outcomes. Education systems' historical response to Roma children has been to place them in segregated classes and schools, which is likely to have the effect of increasing their marginalization, but a series of reports on priority policies to tackle educational disadvantage in Europe (Demeuse et al., 2012) suggests that alternative approaches have begun to emerge in recent years. These catalogue how the University of Ioannina in Greece undertook a Roma education programme in the late 1990s and early 2000s which comprised research on living and educational conditions of Roma in Greece, follow up and teaching support for Roma children and, more specifically:

- mediating between the school and family to better inform the family about the importance of school and to build a relationship with the schools;
- providing educational intervention support from teaching support centres for school integration;
- putting music laboratories in place to increase the value of cultural capital and its articulation with language instruction;
- developing a special database to monitor schooling (enrolment, drop-out, specialized knowledge such as music) and children by class, school, town, department, and region; and
- promoting media intervention to disseminate information and increase awareness of public opinion.

As Varnava-Skoura et al. (2012) state:

According to the official external assessment, there is a gap between the main goals and how the actions were applied ... despite these difficulties, however, authorities maintain the programme's necessity for integrating Romani children into the educational system.

Rus (2012) reports a range of measures taken in Romania to improve outcomes for Roma children. These include the creation of second-chance (effectively intensive remediation) classes for children who have failed to complete primary or secondary school, reservation of places for Roma students in high schools and universities, enhancement of teaching and learning in Romani language, employment of Roma mediators between schools and communities and training in intercultural education for non-Roma teachers.

Overall, priority policies have had mixed success. Some initiatives – or at least some aspects of them – have undoubtedly had positive impacts on outcomes for otherwise disadvantaged children, and it is reasonable to suppose that these have in some cases translated into better life chances and ultimately into better health outcomes. It is nevertheless difficult to find policies that have had a significant widespread effect sustained over time. Put simply, policies of this kind are constantly swimming against a powerful tide created by the socioeconomic marginalization of the students they target and the established structures and practices of education systems that often simply reinforce marginalization. Priority policies themselves tend to be somewhat marginal within education systems, flourishing under favourable economic and political circumstances but always vulnerable to being changed or cut when times are more difficult. Not surprisingly, these policies tend at best to be ameliorative rather than transformative in effect.

3.4.6 Area-based initiatives

Priority policies targeting schools serving disadvantaged areas and efforts to extend schools' roles sometimes develop into, or are incorporated within, comprehensive area-based initiatives for tackling poor outcomes in the most disadvantaged communities. These are highly variable but may involve elements of economic regeneration, housing development, integration of community services at local level and extended educational provision.

A typical example is the Ballymun initiative in Dublin, Ireland. Ballymun is one of the poorest areas in the city and was at one time notorious for its social problems – not least among children. Physical regeneration of the area has been accompanied by the establishment of a government-funded but locally governed partnership that works on ensuring the availability of high-quality child care, promoting community development (particularly involving the most vulnerable community members), supporting residents into employment, developing a coordinated school and lifelong learning strategy for the area and promoting the area's economic development. As in many similar initiatives, the distinctive contribution of the area-based focus of the approach is the partnership's ability to bring parties together, develop coordinated strategies and attract new resources into the area to implement them.

An interesting United States example has attracted a good deal of attention in Europe. This is the Harlem Children's Zone (HCZ) in New York, which works on the principle that tackling issues for children living in disadvantaged areas one by one is unlikely to be effective. It therefore aims to address a wide range of family and community issues simultaneously and in a coordinated way to support children's development. On this basis, it has brought together clear educational pathways from early childhood to adulthood, school improvement and reform strategies, social and health interventions for children and families and community development strategies. There is probably nothing in HCZ that cannot be found in one form or another in European countries, but its significance for policy-makers is that its rationale and strategies have been articulated clearly and have to some extent been packaged in the form of "promise neighborhoods" (PolicyLink, 2011), which are being disseminated across the United States and beyond. Not

surprisingly, there are now attempts to develop variants of children's zones on this side of the Atlantic (Dyson et al., 2012).

In principle, area-based initiatives offer a powerful means of tackling the problems facing children living in disadvantaged areas. They recognize that the problems are interconnected and make simultaneous attempts to intervene across a range of contexts – family, school, neighbourhood – in which children learn and develop. The focus on relatively small geographic areas makes it easier for services to work together, resources to be pooled and coordinated strategies to be formulated. In contrast to strategies for overall improvement, they offer a means of targeting those who face the greatest difficulties and, consequently, of equalizing outcomes.

Initiatives of this kind are notoriously difficult to evaluate, however, and the evaluation evidence available suggests outcomes may be ameliorative rather than transformative (see Dyson & Kerr (2011) for an overview), perhaps in part because the most significant impacts are only likely to be felt in the long term. Targeting in such initiatives is also an issue in terms of the identification of appropriate areas and of the extent to which the most disadvantaged children can be reached efficiently by targeting the areas in which many – but by no means all – typically live.

3.4.7 Inclusive education

Many European education systems have adopted the kinds of inclusive education policies advocated by UNESCO (2009). Inclusive education can have many meanings, but usually refers to breaking down barriers within schools and the wider education system that deny access to educational opportunities for marginalized groups. It has its origins in concerns about the segregation of disabled children in many systems, so relates to wider issues in the well-being of disabled people. The principles of inclusion are, however, often generalized to include other groups who are held to be marginalized in analogous ways.

Inclusive education offers a potential means of equalizing outcomes for these groups and constitutes a more radical approach than additional interventions offered by priority policies. The development of approaches to exclusion in Poland is typical of what has happened in many countries (Box 3.10).

Poland's experiences are not atypical of those elsewhere in Europe. The idea of inclusive education – whether articulated in official policy texts or not – shifts the emphasis away from students' supposed deficits to systemic barriers that keep them marginalized in schools, leading to reforms and initiatives that can reduce the barriers in some situations. There are ways, therefore, in which the education systems of many European countries are more inclusive – and therefore offer more equal opportunities – than they were two or three decades ago.

Systemic reform is nevertheless difficult to implement in the face of forces that create barriers in the school system. The Polish case example (Box 3.10) noted concerns about parents and lack of funding, but other countries might be faced with barriers related to teachers' concerns and policy-makers' narrow focus on the attainments of relatively high-achieving students.

Box 3.10. Poland case example

Poland has attempted to tackle three kinds of exclusion – structural (caused by education, income and place of living), physical (health- or disability-related) and normative (related to alcohol and substance abuse and delinquency). Current approaches for levelling educational opportunities for those with chronic illnesses were comprehensively reformed in 1999, with goals of strengthening the position of teachers, establishing a common preschool curriculum, lowering compulsory education to age six and implementing a reform programme of at every education stage. Educationalists and psychologists working with teachers were enabled to broaden their knowledge, allowing teachers to offer students psychological and pedagogical support, and the “safe and friendly school” government programme produced handbooks outlining educational needs of individuals with specific illnesses.

The requirement to overcome prejudices and stereotypes was identified as a priority but has proved difficult to translate from national to local level.

NGOs ran campaigns to prevent social exclusion as a result of poverty, lack of parental care or chronic diseases, typically collecting funds for treatment and rehabilitation of children with specific needs. Foundations are most likely to care for children in difficult living conditions, but care can only be provided when family members report the need. Media campaigns have been employed to spread awareness, with text messages, billboards, web pages, social media sites, posters, leaflets, television, stamps, Internet radio, newspapers and cinema advertising being used to support the inclusion of sick and disabled children.

These interventions faced several barriers, primarily parental attitudes. Parents were generally reluctant to include children with special education needs in mainstream classes due to fear of a consequent lowering of teaching and education levels. NGOs, which depend almost entirely on external funding, found public administration frequently hindering their daily operations through excessive bureaucracy, although the development of memorable slogans and recruitment of celebrities to deliver them have raised the profile of campaigns and increased financial support. Expanding the scope and activity of NGOs and local initiatives is seen as part of the process of constructing civil society.

As with priority policies, the effects of inclusive education have tended to be ameliorative rather than transformative, but substantial international experience exists on developing inclusive education in ways that avoid – or at least help to avoid – these problems. Some of that experience, drawn from more- and less-affluent countries, has been distilled by UNESCO (UNESCO, 2001; 2009) and is perhaps worthy of national and local policy-makers’ attention.

3.4.8 Overarching integrated approaches

Chapter 2 made much of the importance of integrated approaches to young children and their families based on a universal, affordable and high-quality ECEC system. High levels of integration are, of course, more difficult and in some ways less appropriate for older children, as

the contexts in which they learn and develop are more diverse and the trajectories they follow increasingly distinctive. Many of the strategies and approaches reviewed here – particularly area-based initiatives – nevertheless rely to a greater or lesser extent on bringing together a range of services and tackling issues simultaneously in a coordinated way. For obvious reasons, this is easiest when coordination and integration attempts are limited to particular places or initiatives, but there is a history in Europe and elsewhere of more ambitious attempts involving the development of long-term, wide-ranging strategies and/or formal integration of services for children and their families.

Multiple examples of service integration aim specifically at improving outcomes for children deemed to be at risk of poor outcomes (see, for instance, OECD (1998b)), based on the assumption that the multiple problems faced by these children are likely to call for powerful coordinated interventions from a range of statutory and voluntary agencies. Probably the most ambitious example of recent years is the attempt in United Kingdom (England) to develop integrated child and family services, as articulated in the *Every child matters* green paper (Department for Education and Skills, 2003) and embodied in the Children Act 2004.

In broad terms, the *Every child matters* initiative created more-or-less integrated structures for children's education, social care and health services at local and national levels while encouraging statutory and voluntary agencies to work within the new integrated frameworks. The new structures prioritized joint strategic planning, sharing of data, pooling of resources and joint commissioning and provision of services. This typically meant the formation of multiprofessional interagency teams at area level, working with or from children's centres and extended schools (described above). Teams worked (in principle, at least) in a coordinated way with individual children and families, maximizing the efficiency of their interventions, avoiding duplication and children being missed by services. Area teams, local managers and national policy-makers were guided by five shared childhood outcomes (be healthy, stay safe, achieve and enjoy, achieve economic well-being and make a contribution) that they were all expected to pursue.

Every child matters is an ambitious example of an attempt to integrate services for children and their families horizontally and vertically. It promoted cross-service collaboration at each level of the system and made possible a greater unity of approach throughout the system by creating a shared set of aims and parallel structures from government to local and delivery levels. The argument for coordinated, strategic approaches of this kind seems unanswerable, but there is an important distinction between integrated strategic approaches at policy level, yielding coordinated action on the ground and the structural integration of organizations working with children. Robust evidence on the actual impacts of structural integration is hard to come by, not least because the outcomes of large-scale structural reforms are notoriously difficult to identify. It is certainly not the case, however, that structural change automatically leads to better services and outcomes; there may even be cases where it gets in the way of effective action (see Warren House Group at Dartington (2004) for a review). Effective coordination may come as much from

cultural factors in the relationships among services and between them and children and families as from the structures within which they are delivered (Moss et al., 1999; Cameron et al., 2009).

The implication for policy-makers would seem to be that coordinated approaches and collaborative practices should be the priority. Organizational structures can certainly facilitate and inhibit the development of these approaches and practices and structural reform may therefore be necessary to strengthen development, but it is not an end in itself: its dangers have to be borne in mind.

3.5 Recommendations

Later childhood is an extremely wide and diverse subject. Children change rapidly during this period, interact with a widening range of environments and engage with many different services. Taken together with the cultural, historical and political differences across Europe, the difficulties in proposing a limited number of conclusions capable of doing justice to all this complexity becomes apparent.

Policy-makers and practitioners are nevertheless required to act to improve and equalize outcomes for children. The following comments arise from this brief survey to inform their work.

1. There is no mystery about the reasons for outcomes being unequal during childhood and inequalities' reflection in unequal adult outcomes – not least in relation to health. Unequal childhood outcomes are commonly rooted in underlying societal and socioeconomic structures and processes. Poor children will usually do worse than their more-affluent peers in societies that tolerate economic inequality, and children from marginalized groups will typically do worse than their mainstream peers in societies that tolerate marginalization. Older children need to grow up with adequate material resources in families capable of offering them effective support and with access to real educational opportunities – yet many do not. Guaranteeing these conditions is the main contribution policy-makers can make to improving and equalizing outcomes.
2. Given existing patterns of inequality, there is much that policy-makers and practitioners can do to ameliorate the worst effects. Multiple strategies, policy initiatives and interventions that can have positive effects exist (insofar as the evidence allows a judgement). There is no evidence, however, that the effects of any one intervention are transformative: they are often short term and limited in scope. Short-term and localized amelioration is not necessarily undesirable, but more sustained, wide-ranging and powerful strategies are likely to be needed to make substantial differences.
3. Central government has a key role in formulating (or leading the formulation of) more strategic approaches. A social determinants approach will typically require coordinated strategies involving cross-sectoral collaboration and the energizing of different system

levels in each sector. This may require some structural reform, though it alone may not produce the desired effects.

4. Many of the interventions and strategies reported here have a significant local component. Actors at local level – school principals, primary care workers, local politicians and the like – often understand best what is needed and what is possible in their own situations. National policy needs to give them room (and some encouragement) to deploy this knowledge. It needs to invest in their professional development so they can take more of a lead in their local situations. Well-trained and committed professionals are key to the success of most initiatives. Their work will often need to be cross-sectoral, so some kind of local coordinating mechanism that brings different sectors together is important.
5. Many approaches currently used to improve and equalize childhood outcomes take the form of short-term projects and initiatives. These often have some positive impacts and are relatively easy to initiate and manage, but they also tend to come and go in rapid succession. Their long-term impact is uncertain and they can demand additional resources over and above those already provided. Efforts to realign and energize existing provision (by, for instance, changing practices and promoting collaborative working) might have greater long-term effects and at less cost. Such changes are difficult to bring about, but shorter-term initiatives may have a place as catalysts for change.
6. Policy efforts commonly focus on working through children’s services – particularly schools – as the most obvious pathway for improving outcomes. This makes sense in that these services are controlled by policy-makers and provide easy access to children. Work with families and in community settings tends to be relatively neglected, however. These settings are more difficult to work with but have a powerful influence on children. Some important opportunities may be being missed here.
7. Schools nevertheless have a particular role to play as key locations through which most children and families can be accessed and as important factors in shaping future outcomes. Much is known about how to raise overall standards of school performance and student attainment, but in the context of efforts to reduce inequalities across a range of childhood and subsequent adult outcomes, consideration also needs to be given to known strategies for reducing the gradient in attainment outcomes, making school systems more inclusive, undertaking health-related initiatives in schools and extending their roles to affect wider areas of children’s and families’ lives.
8. Children and young people are not simply the passive recipients of services, but are agents in their own development. Approaches that involve children in making sense of their worlds and develop their capacity for informed decision-making seem particularly promising. Participatory and action-oriented teaching and learning approaches (inspired

perhaps by the ENHPS) seem to work in communities with fewer resources and among vulnerable young people, though more intensive approaches may be needed for those facing the greatest difficulties.

9. Data and evaluative evidence are crucial for developing effective approaches to improving and equalizing outcomes. Countries need to know how their young people are doing, their current presenting problems and the direction of change (if any). Well-established data systems in Europe include the HBSC study. Leaders need to know the effectiveness of interventions introduced, the nature of their effective components and how they can be improved, but many European countries have limited information on outcomes for their young people, especially in middle childhood and the later teenage years, and many interventions are introduced without proper evaluation. This makes it very difficult to be sure whether the situation for young people is improving or to identify which interventions are most effective and in what circumstances. Most countries therefore need good monitoring and evaluation systems, and universities should be supported in undertaking applied research in this field.

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4. Conclusions

There are two problems in drawing a manageable number of conclusions from the task group's work.

The first is that the field of early years, childhood, family and education is extremely wide. The broad conclusions below should therefore be read in conjunction with more detailed recommendations made throughout the report.

Second, it is extraordinarily difficult to draw conclusions that apply to the diversity of nations within the European Region. Virtually all countries have their strengths and weaknesses. Inevitably, those with more resources will have more fully developed systems for early years, education, family support and health care. These systems have been in place over long periods, however, and are likely to be more rigid and harder to reform than new emerging systems in less-wealthy countries. The conclusions therefore tend to reflect what has been learned from systems already in place that have been observed and evaluated over many years. The description below of the essential context for progress, characteristics of best systems and barriers encountered may help some countries as they make key decisions on priorities for public spending in times that are challenging for all.

4.1 The importance of political will and leadership

Investments in children, particularly those specifically designed to reduce the effect of inequality, take many years to show positive results. It is critical that politicians at the most senior level in democratic countries understand and show support for such investments. Results are rarely evident within electoral cycles, and redistribution to counteract the effects of poverty is often not popular with voters. Government engagement at all levels is an essential condition for progress to be made on reducing health inequalities. This must be matched by progressive investments in health, education and family support services for children and families. At service level, head teachers and senior officers in social care and health provision need to be visibly committed to reducing health inequalities for change to happen on the ground.

4.2 A multistrand, multilevel approach

All the country case studies demonstrate the complexity of action required to narrow the gap in health outcomes between social classes. Action needs to be taken at macro level, including national minimum requirements as a baseline of services for all. National standards need to include clear statements on citizens' entitlement to services, minimum service standards and systems for delivery accountability. At the next level down, institutions need to be committed to reaching and improving minimum standards and staff working directly with children and families can and should play a key role in improving the conditions that lead to poor outcomes, such as low educational attainment, dilapidated housing and poor physical environments. They can also contribute to activities related to specific health outcomes, such as encouraging physical activity, promoting healthy eating and offering good sex and relationships education.

Services, however, are only part of the solution. Improving employment opportunities and progressive tax and benefit systems help to reduce poverty levels, thereby lessening the health risks of living on a low income. These, again, are macro-level issues requiring concerted effort at the highest levels.

4.3 Horizontal and vertical integration of policy and practice

So-called “silo” working – meaning each agency or institution working independently and failing to make the synergies necessary for real progress – is a major barrier for countries with well-developed systems. Horizontal integration means health, education, social welfare and nongovernmental bodies working together, encouraging efficiencies of action and increasing the likelihood of reaching the most disadvantaged families. Vertical integration assumes top-level policies are consistent with local action, but not so rigid as to constrain service design appropriate to local need. Both forms of integration can result in improved outcomes. Top-down and bottom-up approaches are required and, critically, their success or failure needs to be widely shared.

Services and resource distribution also have an effect. Much is now known about the importance of, and potential savings achieved through, early investment. Investment in many countries is weighted disproportionately towards older children, dealing particularly with problems that might have been prevented by earlier intervention (OECD, 2009). This is not a case for *disinvesting* in later childhood and in schooling, but it does signal a need to ensure that investment in younger children is given an appropriately high priority. Countries with the highest investment in early years tend to have better outcomes overall. An integrated approach would have a universal offer including high-quality ante- and postnatal care and preschool and school provision, with good systems of transfer and communication across the health, early education and statutory school sectors. Funding within a universal framework should concentrate on areas and families with the greatest needs. Most health systems are designed to ensure a basic level of universal health screening procedures for all (vision and hearing tests, for example), but health resources beyond basic screening are allocated according to individual health need. Considering such redistribution for systems like education and encouraging greater funding to be allocated to those doing least (rather than most) well could greatly reduce inequality in educational results that over the lifetime indicate poor health with consequent greater health spending.

4.4 User involvement: essential, but not sufficient

Many of the school-based health interventions described above emphasize the importance of involving children and young people in designing programmes and remedial actions on issues such as diet and obesity reduction. This is in sharp contrast to the emphasis on evidence-based interventions delivered with fidelity to a particular model. Given the importance of parenting throughout childhood, improving parenting through programmes that have been shown to be successful certainly makes sense, but such programmes are voluntary: it is often difficult to get those who would benefit most to join. The key conclusion is that techniques are needed to ensure

participation that values and respects children's and parents' personal experience and preferences. Once respect and trust has been established, it is significantly easier to encourage participation in evidence-based programmes.

4.5 The importance of data

Data are crucial for planning, implementing and evaluating public services. It is not surprising that wealthier countries have more to contribute to reviews of effective strategies, partly because they tend to have much better-established systems for collecting and evaluating population data. Data are needed at all levels to ensure accurate delivery of services and, just as important, ensure they are having the desired effect. Wide variation of outcomes exist within and across nations: without fine-grained data on variation, decisions on where to target resources will be based on political expediency rather than evidence of need. Data tell us what is and is not working effectively and indicate how scarce resources could be better deployed. Strategic decision-making requires cross-agency data sharing on the basis of which intelligent, rather than ad hoc, decisions can be made about local needs.

Data sharing on a local basis is also critically important. Some of the most publicized cases of failure to protect children from abuse and neglect have arisen partly as a result of agencies' failure to communicate. Data sharing goes hand in hand with front-line service integration. Agencies cannot work together if they do not have a shared understanding of problems faced and their respective roles in creating solutions.

4.6 NGOs' roles

NGOs have played a key role in the delivery of innovation. International NGOs are critical in the delivery of many basic services in the poorest countries in the European Region. National NGOs, funded by the state, foundations and charitable donations, also play a major role, particularly in family support but also (to a lesser extent) in supplementary education activities. While these organizations deliver high value in some areas, they are inevitably patchy in their reach. At best, they offer innovative ideas that help to build an evidence base for new solutions to old problems. Few examples exist, however, of NGO activity being scaled up to achieve system reform. Government at all levels is responsible for ensuring minimum quantity and quality of delivery, but NGOs have key roles in areas such as demonstrating how that minimum could be greatly improved, showing the difference expansion in eligibility or quality improvements could make.

4.7 Quality staff, management and leadership

Countries with better health outcomes have less inequality in child outcomes. This is particularly true for the Scandinavian countries. A key common feature in the Nordic area is the respect accorded to, and training required for, those working with children in school and early years settings. The early years case study from United Kingdom (England) showed clearly that staff qualifications had a direct impact on children's outcomes, but enormous diversity exists among

European countries in relation to salaries, public esteem and entry barriers for those teaching or working in preschool settings.

Managers need to be able to command respect from colleagues in other areas to ensure the kind of cross-agency working necessary to improve service quality. It is usually accorded to senior managers in schools but less often to those in child care, where it could be argued that collaboration across health and social care is just as important. Without concerted effort to improve training requirements for working with children (particularly in child care) and enhance career and salary structures, it is unlikely that necessary quality improvements will be achieved.

4.8 The need for more evidence

Disappointingly, few examples of work with school-aged children in a non-school setting emerged from case studies commissioned for this report from a wide range of countries. Research on non-school interventions' effectiveness with children over six years seems particularly scant. Behaviours highly risky to health begin in late childhood and early adolescence and pressure on parents increases as children grow older. Exposure to alcohol, drugs and early sexual experiences has potentially lifelong consequences, yet little seems to be known about programmes, activities or support systems to encourage well-being outside of school settings: activities receive investment, but little is known about effectiveness. This is a serious gap in the evidence base that should be addressed.

4.9 Reference

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

This is a three-volume collection of case studies, only available online, that was commissioned by the task group on early years, families and education. Go to the web site of the WHO Regional Office for Europe to access the volumes.

Volume 1. Early years

(<http://www.euro.who.int/en/publications/abstracts/improving-the-lives-of-children-and-young-people-case-studies-from-europe.-volume-1.-early-years>)

Volume 2. Childhood

(<http://www.euro.who.int/en/publications/abstracts/improving-the-lives-of-children-and-young-people-case-studies-from-europe.-volume-2.-childhood>)

Volume 3. School

(<http://www.euro.who.int/en/publications/abstracts/improving-the-lives-of-children-and-young-people-case-studies-from-europe.-volume-3.-school>)

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