



EARLY CHILD DEVELOPMENT:

Report on case studies

Joana Morrison, Peter Goldblatt, Hynek Pikhart & Milagros Ruiz

Authors:

Joana Morrison, Peter Goldblatt, Hynek Pikhart & Milagros Ruiz

Acknowledgements:

Sabine Haas, Gesundheit Österreich, Austria; Jana Hainsworth, Eurochild, Belgium; Maria Herczog, Family Child Youth Association, Hungary; Sharon Lyons, Early Years, Northern Ireland; Marion Macleod, Children in Scotland, Scotland; Eva Flora Varga, Family Child Youth Association, Hungary; Maria Roth, Cluj University, Romania; Marion Weigl, Gesundheit Österreich, Austria; Pauline Welmsley, Early Years, Northern Ireland.

Published as part of the DRIVERS project by:

Research Department of Epidemiology and Public Health

University College London

1-19 Torrington Place

London WC1E 6BT

UK

Tel: +44-20-7679-1906

Correspondence: h.pikhart@ucl.ac.uk

Suggested reference:

Morrison J, Goldblatt P, Pikhart H, Ruiz M. Early child development: Report on case studies. Report produced as part of the 'DRIVERS for Health Equity' project. Research Department of Epidemiology and Public Health, University College London. London: 2015. Available from: <http://health-gradient.eu/>.



This work is licensed under a Creative Commons Attribution-NonCommercial ShareAlike 4.0 International Licence.

You are encouraged to:

Share: copy and redistribute the material in any medium or format

Under the following terms:

Attribution: You must give appropriate credit, provide a link to the licence, and indicate if changes were made. You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.

Non-Commercial: You may not use the material for commercial purposes.

No Derivatives: If you transform or build upon the material you may not distribute the modified material.

No additional restrictions: You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits.

To consult the full licence text visit: <http://creativecommons.org/licenses/by-nc-nd/4.0/>.



The research leading to these results was done within the framework of the DRIVERS project (www.health-gradient.eu) coordinated by EuroHealthNet, and has received funding from the European Community (FP7 2007-2013) under grant agreement no 278350.

Table of Contents

Introduction	2
Case study methodology	4
Results	10
Toybox	10
Netzwerk Familie	13
Sure Start Hungary	17
Universal Health Visitor System	21
Theotokos Centre	24
Discussion	29
CONCLUSIONS AND RECOMMENDATIONS	34
REFERENCES	36
ANNEXES	39

Introduction

The objective of case studies in areas that are key drivers of health inequities is to identify services, policies or practices that are already in place that have the potential to reduce inequalities in health and its social determinants. The early years case studies described in this report relate to one of the three key areas - early childhood development - covered by the DRIVERS project – The other areas being employment and working conditions and income, welfare and social protection. Case studies were also conducted on advocacy for health equity. To achieve the objective described above, five early years case studies were selected from a longer list of proposals - using the methodology described below- and in-depth investigations were carried out to identify the efficacy, reach and possible transferability and scalability of the interventions represented by the studies. To do this, explanations were developed of what works for which groups of people in what situations. The methodologies used to achieve this are also described below.

The DRIVERS Project [2012-2014] – a three-year research project funded by the European Union 7th Framework Programme-focuses on three of the key drivers to reduce health inequities: early childhood development, fair employment and working conditions, and welfare, income and social protection. It assesses the impact of policies and programmes, to develop new methods and evidence, and provide policy recommendations and advocacy guidance to reduce health inequalities within Europe (1).

Early years interventions that are designed to reduce inequalities in health and development and their social determinants must focus on actions which give all children the best start in life and are delivered with an intensity proportionate to the social needs of the children and their families (2-4). The Driver's ECD case studies were selected so as to represent a range of services that, on paper, appeared to have the potential to be rolled out in this way.

Ensuring the best start in life for children can be achieved by improving outcomes in the different domains of early child development -cognitive, communication and language, social and emotional and physical (5-7). The interventions may be aimed at children, their parents or both. The objective of this study was to identify, describe and explore interventions, services and programmes was aimed at ensuring the best start for children by reducing inequalities in health and development and their social determinants (8-11). Those case studies reviewed were proposed and implemented by third parties: not-for-profit organisations, agencies and statutory bodies working to promote health and equity. These form part of the Eurochild and EuroHealthNet networks and they collected and analysed the data in collaboration with work package leaders (1).

Key questions

- Is there evidence that the case studies delivered improvements in the domains of child development that could contribute to subsequent reductions in inequalities in health?
- How do the services investigated deliver improvements in child development in the early years?
- Do the services provided reach all of their target groups? Are these the children and families who would benefit most?
- Could the interventions be transferred to other countries and be effective with comparable target groups?
- Could they be rolled out with sufficient scale and intensity to impact on the magnitude of health inequalities?

Case study methodology

Methodological development

We carried out a descriptive and exploratory qualitative study to capture early years programmes' staff and users' unique accounts of reality in order to report their knowledge on inequalities in ECD and health. Data was collected from five countries: Austria, Hungary, Northern Ireland, Romania and Scotland participating in the Drivers project as third parties.

Characteristics of the participating interventions and methods of their selection

Eurochild and EuroHealthNet's third parties responded to questionnaires designed by UCL which collected extensive information on the following ten interventions: 1) Family Network, a targeted referral service in Austria, 2) Prolepsis, a Programme on food aid and promotion of healthy nutrition in Greece, 3) Sure Start, Hungary, 4) a mother-baby unit for teenage mothers in Hungary, 5) the universal health visitor service in Hungary, 6) Eager and Able to Learn in Northern Ireland, 7) Toybox in Northern Ireland, 8) the Iris maternal centre in Romania, 9) the Theotokos mother and child centre in Romania, 10) The Mother's Club in Romania. Information was also provided on Growing Up in Scotland (GUS), a longitudinal cohort study in Scotland.

The following selection criteria were then applied to choose the interventions to provide a balanced mix of projects and country representation:

- **Country coverage:** ensure the selected interventions encompass sufficient range of countries to reflect the different contexts in Europe.
- **Aimed at children before they enter school:** the target group is aged 0 to the start of primary schooling.
- **Potential to reduce inequalities:** actions taken are credible ways of addressing inequalities in health and development and their determinants.
- **Addresses developmental domains:** interventions need to address at least one domain of child development. Targeting more than one is desirable but not essential.
- **Parenting:** it is desirable that, by helping with parenting skills and or financial or other support needed for daily living, interventions contribute to creating the conditions for improving nurturing and healthy development.
- **Evaluation:** the intervention has undergone an evaluation or there is a prospect of carrying it out in the time available.

Based on these criteria, the interventions described below were selected:

1. The **Family Network in Austria**: a targeted referral service aimed at families in need, with children aged 0-2.
2. **Sure Start** and the **Universal Medical Visitor** service from Hungary in order to combine assessing the transferability of an intervention designed in a different country/context and a universal intervention.
3. **Toybox** from Northern Ireland. An intervention aimed at reaching out to Traveller families to enhance the social, educational, emotional, physical, language and cognitive development of children.
4. **The Theotokos Centre** from Romania is aimed at providing unemployed and Roma single mothers and their children with child-care support and programmed activities such as parenting advice.

5. Separate discussions were held with Children in Scotland to identify interventions in Scotland, as a result of which the following three interventions were selected: **The Lickety Leap** theatre production consisting of drama, storytelling and improvisation supporting children's cognitive development and personal efficacy; **the Ruchazie Family Centre** delivering integrated early childhood education and care and outreach support to families in deprived areas; and **the North Ayrshire** early years service for two year olds providing support for parents and positive learning experiences for children in pre-school education.

Brief description of the selected interventions

Toybox, Northern Ireland

Toybox, in partnership with parents and children was set up in 2003 across Northern Ireland to provide rights based outreach play services to Traveller families with children aged 0-4 years. Its aims are to enhance the social, educational, emotional, physical, language and cognitive development of children as well as strengthen the capacity of Traveller parents to support their children's well-being and eagerness to learn. Families involved in the project live in deprived areas in Northern Ireland.

Through weekly home visits by Project Workers, parents with their children, engage in the High Scope (12) method of play which supports, challenges and stimulates the children's interest in learning and prepares them for education. At present a team of 10 Project Workers deliver this programme to over 220 families and 317 children across Northern Ireland.

Netzwerk Familie, Austria

The *Netzwerk Familie* (NF) programme was developed and tested during the years 2009-2010 as one of three pilot programmes implemented based on a call for early child interventions published by the regional government. NF is an institutional co-operation of the social services of Vorarlberg and the provincial specialist's association of paediatricians. On the basis of the evaluation it was selected for the roll out throughout the whole province of Vorarlberg, which started in 2010. In the year 2014 it was selected as a model project for the implementation of early childhood networks in all nine Austrian provinces. The general objective of NF is to reduce health inequality by supporting early child development among families in need. It systematically identifies families of children aged 0-3 in need with the help of the social and health system, ensuring they receive specific support and counseling. They also accompany them during specific periods when required.

Sure Start, Hungary

The Sure Start program is provided to families with children 0-5. Sure Start premises, called "houses" in Hungary provide mothers - or other caregivers - and their children planned activities delivered by trained staff. The program aims to reach families from diverse backgrounds to promote mutual learning and support as well as integration of deprived and/or minority- mostly Roma-children and their parents into the community. The program is delivered in the 36 most deprived sub-regions in Hungary. There are very limited day care opportunities for children under 3 and many of them start kindergarten at age 5—the compulsory starting age. Sure Start Hungary is aimed at reaching children during the early

years and strengthening parenting capacities, also providing advice and support to women to seek employment.

Universal health visitation system, Hungary

Health visits delivered at home for expecting mothers and children. The programme has universal coverage and its aims are to give advice on infant care and children, prevent unwanted pregnancies, detect child abuse and maternal depression. Funding is provided by the central government.

Theotokos Centre

The aim of the Theotokos Centre is to offer child-care support to single mothers and families in difficult situation, preventing mother-child relation disruptions and child abandonment. The target group are mothers who lack social or/and financial support in raising their children. In terms of ethnicity, the majority of mothers are ethnic Roma (60%), the rest being Romanian or Hungarian, their ages are between 14 and 25 years and they are mostly unemployed. The initiative has several components addressed to mothers and their children, mainly full day care services for children aged 0 to 2 years, but also counselling, information services and health-care services for parents, especially single or disadvantaged mothers. As specific objectives, the centre aims to ground the mother-child relationship on a solid parenting skills background, and also give children a healthy and skilful early development.

Lickety Leap, the Ruchazie Family Centre and the North Ayrshire early years service, Scotland

The Licketyspit Theatre Company, focusing on its LicketyLeap production, used drama, storytelling and improvisation to support children's cognitive development and personal efficacy in disadvantaged communities and engaged their parents in sustaining the effects of the intervention. The Ruchazie Family Centre provided a wide range of support, advice and information services for local families in East Glasgow. It was staffed by a multi-disciplinary team and provided integrated early childhood education and care, outreach support for parents and direct work with families and children. It was delivered and planned in a flexible way responding to the needs of recipients. The centre was accessible to any family in the community and accepted referrals from other services therefore providing a universal service. It encouraged mutual support among families and developed a sense of cohesion in the community. Emotional support was provided in a safe environment by qualified staff. The North Ayrshire Council piloted the inclusion of at-risk two year olds in their pre-school education provision, normally available to three and four year olds. The programme included provision of a wide range of age appropriate play equipment, parent groups and individual parent support.

Socioeconomic profile of the intervention areas

Indicator	UK	Austria	Hungary	Romania	Year of the indicator
Percent of population aged 0 – 15 years	17.6	14.4	14.5	15.5	2013
Percent of employed population aged 15-64 years who are women	45.1	46.1	45.6	42.4	2013
Unemployment rate (%)	5.1	5	10.3	7.6	2013
Percent of children aged under 18 in poverty	9.8	8.2	9.4	24.9	2010
Percent of children aged 0-5 years living in overcrowded conditions	29	44	80	71.3 ¹	2010
Public spending on family services as a percentage of GDP	1.38	0.57	1.16	2.2	2009
Children aged 0-3 years in formal child care	73	87	92	85	2012

Notes

¹ For Romania, the indicator is percent of children aged under 18 years living in overcrowded conditions

Sources: International Labour Organization (14), Organisation for Economic Co-operation and Development (15) and the European Commission (16).

Study sample

Third parties identified and interviewed 25 parents, programme managers and key professionals -from within the selected interventions- for in-depth, semi structured interviews. They also liaised with the programme managers to identify potentially ideal staff and parents -also involved in the interventions- for the focus groups. A final sample of 46 respondents participated. The participants and number of interviews for each case study are detailed below. This methodology was not used in Scotland.

Toybox

- Ten parents/carers interviewed at home
- One focus group with 10 staff

Netzwerk Familie

- Two interviews with the heads of NF at their premises
- One interview with the person responsible for child and youth welfare in the provincial government at the premises of the provincial government in Bregenz
- One interview with the chairman of the provincial specialists association of paediatricians in Vienna
- One focus group with 11 cooperation partners
- One group interview with 4 mothers/fathers

Sure Start Hungary

- One interview with the expert who adapted the service to Hungary
- One interview with a Sure Start program manager in Budapest
- One focus group with 8 mothers attending Sure Start centres
- One focus group with 8 mothers benefitting from Sure Start and the universal health visitor programme

Universal health visitor programme

- One interview with a health visitor from a rural area
- One interview with a health visitor from the suburbs of Budapest
- One interview with a supervisor of health visitors in Budapest

Theotokos centre

- Four individual interviews with women who had attended the centre
- Two individual interviews with staff working at the centre
- One focus group with four mothers attending the centre

Data collection

ECD quantitative data collection

Third parties collected quantitative data available in relevant reports or other documents such as written records or official statistics to compliment the data already provided in the first template.

ECD qualitative data collection

Qualitative methods were used to provide non-quantitative data such as user's or professionals' knowledge, perceptions and beliefs (13). Third parties used the following qualitative methods in this study: individual in-depth interviews and group interviews; namely focus groups and followed the criteria for reporting qualitative research suggested by Tong and colleagues (17), where appropriate. A description of the methodological development and data collection is provided below.

Individual in-depth interviews

Third parties identified and interviewed 25 parents, programme managers and key professionals in total for selected interventions and collected information on the aforementioned key questions, following the interview guide provided below in Annex 4. The guide described the issues or questions to be explored. It was developed based on the key questions and the objectives as described in the Description of Work (DOW).

Third parties carried out the interviews lasting at least one hour in their native language. They provided a comprehensive summary of the interviews translated to English to lead partners. Interviews were the preferred method for hard to reach groups or high level managers, for example.

Focus groups

Third parties liaised with the programme managers to identify a potential group of ideal participants for the focus groups.

Group interviews were used as a method for data collection as they provide valuable and rich information due to the dynamics of group discussion (13, 18). Furthermore, the interactions and influences taking place provide in-depth information. It may also help to reflect the everyday reality by reproducing a real life environment and its social interactions (14).

Each focus group had approximately 6-10 participants, with similar socio-economic backgrounds, age and occupation and lasted approximately 1,45 hours. There were 46 participants in total. The moderator guided the discussion partially, following the discussion topic guide provided, developed with the same criteria as the interview guide. The narrator took notes and recorded the sessions. Staff had the opportunity to ask any questions before we commenced however, no questions were asked. At the end of the session the narrator offered a short summary of the issues discussed so participants could add or rectify information.

Ethical considerations

Informed written and verbal consent was obtained from all the participants for taking notes or recording the sessions. The information was anonymised and confidential. Participants from the Netzwerk Familie case studies received a small payment.

Results

The information obtained from the interviews and focus groups is described below for each intervention. This includes respondent's perceptions of the intervention. For each intervention the information is organised according to headings that emerged from each of the case studies, based on the structure listed in the interview guide (Figure 1).

Toybox

A. Interviews with parents and/or carers

Socioeconomic context of the area and users receiving the service

There was a mixed response when describing the socioeconomic background of the area where Toybox is delivered. The main issues identified by respondents were unemployment; social housing, racism, benefits and a nice area to live. Most parents described unemployment as an important issue and while many parents liked where they lived, there were little or no amenities for their children.

Intervention delivered and objectives

It was generally agreed by all interviewed parents that Toybox consists of learning through play with their child/ren. Some of the activities identified were; reading, jigsaws, outdoor play, making cards, singing and building. Eight of the ten parents said Toybox was delivered to their family at their home.

Providing support for parents

Parents mentioned additional activities related to the service including workshops, help with making appointments for other services and transition support.

Domains of development

All parents agreed that the project impacted positively on their child's development. Parents identified improvements in development in several of their children's skills. One parent explained that health workers had remarked upon improvements in their children's vocabulary. Another explained that Toybox had helped in their children's development because staff from the programme helped them get into SureStart. Other responses listed aquiring skills such as reading.

"JC has become a lot more sure of himself"; "It's helped with their speech and they play better together." Toybox parents.

Methods use to reach beneficiaries

Principal contact methods were other family members, health visitors and project workers providing home visits, the later identified as the most common. Five parents described other services delivered to them such as: SureStart, After School, Play Club and Safe and Well programmes.

Information on evaluations conducted

Three parents personally acknowledged the work of Toybox by saying how much they enjoyed the programme. They also referred to strong, positive and relaxing relationships established with their child and staff worker.

Barriers and enablers

Parents explained that finding childcare when they had courses to attend was sometimes a problem. Also, some mothers did not feel comfortable if men participated in the courses delivered in community areas. The culture of travelling was also identified as a potential barrier in addition to feuds, weddings and funerals. Positive enablers however, were also identified by parents, these included trust and confidence in the staff delivering the project.

B: Focus group with Toybox staff

Socioeconomic context of the area and users receiving the service

There were many points of agreement among staff when describing the social and economic backgrounds of the main users of the intervention; lack of jobs, families living in social housing, single parents, parents with low education, drugs, alcohol abuse and large families which were often unstructured.

“...inherited class system, dysfunctional families, lack of jobs and a lot of barriers.”

Toybox staff

Intervention delivered and objectives

The activities carried out within Toybox were aimed at enhancing the global development of Traveller children ages 0-4. Informants also explained that a further objective was strengthening parents' capacity to assist in their children's learning and development by supporting and empowering parents to develop their own educational skills. The respondents referred to other aims such as encouraging and supporting parents/families to become involved in community activities, promoting and supporting the recognition and representation of Traveller culture in all areas of work and policy.

“It has improved the confidence and relationships between Toybox workers and Traveller parents’ by bringing the project into the homes of Travellers.” Toybox staff

The programme was described by respondents as being mostly in families' homes.

Addressing potential inequalities in early child development

The staff interviewed felt that Toybox was able to establish a link between parents and health care services as they assisted parents-during Toybox visits-in managing forthcoming appointments and accompanied them. Community events delivered by Toybox ensured that families had access to relevant health information regarding smoking, nutrition and road safety. Some staff gave personal accounts of the impact these events had including families working closer with other services, mothers considering joining new groups such as breast feeding groups and parents hearing about and receiving vouchers they were entitled to. Also, staff explained that participants had access to fresh fruit in Toybox play sessions which increased their opportunity to taste, smell and eat new types of fruit.

“Dads were happiest when engaging in construction like play.” Toybox staff

The staff described the High Scope-based practice during the play session and the child observation record booklets which helped them identify needs and highlight children's achievements.

Providing support for families

Staff felt that the trusting relationship they had built with parents was very important for children's health and development and this was achieved by staff members visiting the same family's home for months and sometimes years.

"The acceptance by families of the service is very important and we have Toybox now visiting different generations of the same family." Toybox staff

One staff member spoke in detail about the wealth of knowledge families have. All staff agreed that parents are important people in their child's lives and another staff member said that the level of support each family received from them varied.

"Ask parents for advice...it is not about doing onto parents..." Toybox staff.

"Told Mum: you're such an important person in your child's life. The parent began to cry when I said this." Toybox staff.

Programmes such as the "cook it programme", for example, were attended to by many parents according to staff. One member felt that parents were satisfied with the content of the programme. Parents shared healthier foods they had learnt to prepare. Staff noted that their role was to support the family only and it was important that this play continued after the project worker left the home.

Domains of development

It was strongly agreed by the interviewees that child development improved with Toybox. Staff felt Toybox included social, emotional, physical, creative and intellectual areas of child development. Their play sessions were planned carefully taking the child's interests and abilities into account and suitable resources selected.

Staff explained that in order to support children's development the engagement of parent/s in play was very important as there is a prominent role for them. Staff noted that their role was to provide families with support but it was important that play continued after the project worker left the home. They also discussed learning outcomes with parent/s.

Methods used to reach beneficiaries

The interviewed staff members explained that Traveller families with children aged 0-4 years living throughout Northern Ireland were the principal beneficiaries. Other people also included in the programme were extended family members living in or near beneficiaries' homes.

Staff described that they initially identified and reached families through various methods; when the project began in 2003 support groups were vital and necessary to identify and reach families. They also listed other services today which are vital in collaborating with and in identifying new families including: practitioners, health visitors, the Public Health Agency, Safe and Well, Barnardos, schools and SureStart. Some Traveller families were self-referred, however, staff felt this was a small number. In some cases, family members identified participants who could be registered on the project.

"Toybox has been a very successful project in engaging Traveller families and supporting the development of Traveller children through play. It is recognised as a successful model in child development especially among disadvantaged groups."

Toybox staff

Information on evaluations conducted

The staff listed on-going evaluations of the project such as yearly surveys, questionnaires and participative evaluations carried out among parents, Sure Start and Early Years internal staff. There was an external evaluation completed in 2007 and three staff summarised his evaluation outcome as a successful model in child development especially among disadvantaged groups. It was also considered to be important in filling the gap between families and other services.

"It has been very successful at filling the gap between families and other services. It has removed barriers to Traveller children entering education."

Barriers or enablers

There was general agreement by staff that there was none or little support or advice for families with children over 4 years of age. Staff expressed the view that families needed this support especially in rural areas and it wasn't available. They felt appointments were missed because of this. Participants also felt that transitioning into school was an issue due to lack of help and support offered by schools and after-schools.

"Families struggle getting doctor's appointment." Toybox staff

Staff agreed they sometimes had problems with other service providers. A range of positive enablers for the implementation of the project were also identified, staff agreed that access to good resources and quality training effectively supported them in their work. The internal knowledge, expertise and experience within the team were identified by one of the newest staff members.

"Services in my area felt Toybox was stepping on their toes and taking over their good work."
Toybox staff

Netzwerk Familie

A: Individual interviews with managers

Socioeconomic context of the area and users receiving the service

The participants explained that Netzwerk Familie reaches approximately 5% of all families with children under the age of 3 who need support. These range from high income families with multiple or premature birth to socioeconomic disadvantaged ones. According to respondents, it was easier to reach families with financial constraints or migrants than young pregnant women described as not fitting into the model of mainstream intervention users, for example women from a high socioeconomic position with postpartum depression. According to the respondents' experience there were some knowledge gaps among cooperation and network partners regarding early child development in Vorarlberg, especially interventions to support bonding between parents and their children. Netzwerk Familie's objectives were to fill these gaps by providing training and organising events with experts.

Intervention delivered and objectives

It is aimed at families who encounter barriers in accessing existing programs. It builds a continuous relationship with the family which is the program's main success factor. They

also explained that there is no knowledge on how many and why some families refuse the referral.

Respondents explained that the programme aimed to cooperate with the health and social sector, however cooperation with some professions was considered difficult-for example with medical doctors. In the recent years other groups such as child care institutions or local government officials were becoming increasingly involved.

Addressing potential inequalities in early child development

The respondents explained that *Netzwerk Familie* helps families in need until the child is three years old. Families are faced with various issues; financial difficulties, violence, social isolation or challenges associated with parenting and caring for their children in addition to children's health problems such as multiple or premature births.

Providing support for parents

Regarding the activities carried out, the participants described a resource developed within *Netzwerk Familie* which is orientated towards families in need. It coordinates interventions for families in a systematic and structured way involving all relevant partners.

Information on evaluations conducted

Netzwerk Familie staff members felt that the family climate improved after receiving support. They described observing improvements in how families deal with their children and partners which, in turn, has positive effects on the early development of children. These improvements were also reported by the families receiving *Netzwerk Familie* services. The staff interviewed explained that a thorough evaluation should be carried out as there is no data in Vorarlberg to show that *Netzwerk Familie* has a positive impact on child and youth welfare.

Barriers and enablers

Staff explained the different conditions for implementing early childhood intervention programs in rural and urban areas which should be considered in program planning. It is challenging to involve local physicians as they need incentives in order to cooperate. *Netzwerk Familie* was introduced as a result of winning a tender which has impeded cooperation in the long term between different partners who competed for it. They described the need for high-level political leadership. They also remarked upon the challenges in reaching young pregnant women or mothers which do not fit into the model of mainstream intervention users such as those from high socioeconomic positions with postpartum depression. Also, in the rural areas receiving benefits from the programme is stigmatising.

B: Focus group with *Netzwerk Familie* parents

Providing support for parents

The parents explained that *Netzwerk Familie* offered support when mothers left the hospital and continued maintaining contact and offering consultation. The continuity of contact and consultation was experienced as helpful by mothers.

Intervention delivered and objectives

One of the parents described being filmed by a *Netzwerk Familie* professional while taking care of her child at home. They later analysed the video and the *Netzwerk Familie* professional explained what could be improved. This activity was seen as very helpful by the mother and she considered it had a positive impact on families.

Addressing potential inequalities in early child development and health

Parents explained how family members' relationships improved after *Netzwerk Familie* visits and daily life in the family atmosphere became more relaxed. Mothers felt more self-confident and structured in their life during and after participating in the *Netzwerk Familie* programme.

Methods used to contact beneficiaries

The parents described how they were referred to the programme. After having given birth, one parent described being approached at the hospital by a parents counselling programme, other parents explained that health care professionals and health care services that are aware of the programme referred them and one was self-referred.

Barriers and enablers

Respondents explained that activities which included fathers had lower attendance than other activities. They also felt that the first contact should not take place immediately after the birth of the child as this was too stressful for mothers. Lack of further service offer after the child's third birthday was also seen as a barrier.

C: Focus group with Netzwerk Familie staff and cooperation partners within the network

Socioeconomic context of the area and users receiving the service

Netzwerk Familie staff and cooperation partners within the network made reference to a lack of programmes for mentally ill mothers, post-partum depressions and mother-child-treatments in health clinics (such as those in Germany) in Vorarlberg. They also referred to a shortage of programmes and group interventions for pregnant women. Specific programmes aimed at women with language barriers were also described as important.

Intervention delivered and objectives

The participants referred to the lack of programmes for pregnant and post natal mothers; *Netzwerk Familie* has the objective of filling this gap. It does so by prioritising the problems a family might be experiencing and finds the right intervention to solve it. Sometimes the problem is hard to identify if there are multiple factors causing stress, in this case *Netzwerk Familie* was perceived by the interviewees as an improvement of the social services delivered. The work of *Netzwerk Familie* was described as facilitating the physician's work by assuring that the families were taken care of and obtaining the most appropriate help for problems outside the medical sector. The round tables and other events enabled cooperation between the partners and *Netzwerk Familie*.

Addressing potential inequalities in early child development and health

The work of *Netzwerk Familie* had a positive impact on the families, according to *Netzwerk Familie* staff and cooperation partners within the network. It was observed by staff that family members dealt better with each other and daily life in the family became more relaxed after the intervention. Another outcome was that women became more self-confident and structured in their life during or after participating in the programme.

Providing support for parents

It was considered important by staff for *Netzwerk Familie* to prioritise the family's problems and find the right intervention to solve it. A challenge for *Netzwerk Familie* staff and cooperation partners within the network was to establish a relationship with the accompanied families and at the same time to refer them to other intervention programmes. Sometimes there are multiple factors that stress a family and they need to be referred to various intervention programmes. In these cases *Netzwerk Familie* was seen as an enrichment of the social services system.

Methods used to contact beneficiaries

Respondents were of the opinion that *Netzwerk Familie* reached their target group in general. However, some families were not reached.

Barriers or enablers

Some *Netzwerk Familie* staff and cooperation partners within the network reported experiences which - from their point of view - show that some families are afraid that *Netzwerk Familie* might cooperate with the child and youth welfare service. This was assumed when they read the information flyer about the intervention programme where the provincial government is listed as a funding source. The main reason families did not accept support offered by *Netzwerk Familie* – according to the cooperation partners- was due to the local attitude (need to cope with situation themselves) and the negative image of “getting help”. They explained that parents feared being reported to social services. The increasing number of ambulant births was also pointed out as a barrier to reaching families as these are harder to identify or approach.

Respondents expressed that there should be no competition between services. Networking with the relevant institutions of the health and social sector was considered important. According to respondents, regional politicians need to share the principles and understand the importance of a programme like *Netzwerk Familie*. If there are existing institutions or structures in a region then these should be used and strengthened. Staff also explained that it was difficult to collaborate across disciplines in the medical sector, especially during the transition from pregnancy to birth and through to childhood. The staff explained that it is useful to have a multi-professional team that works with the families within the programme.

Sure Start Hungary

A: Individual interviews with managers

Socioeconomic context of the area and users receiving the service

The interviewed staff explained that the Hungarian adaptation of Sure Start was developed in order to support children and their families to reduce health and social inequalities in the most deprived micro-regions in the country. The local social and child welfare services were described as overburdened, under-resourced and often not able to provide the necessary support.

“Budapest the House provides services in the most disadvantaged district with a high ratio of Roma and immigrant, primarily Chinese population...The local social and child welfare services are overloaded, under resourced and often not able providing the necessary support.” Sure Start manager

Intervention delivered and objectives

Interviewees described the structure of the programme which included an intensive 360 hour-long training program with four aims: to ensure the optimal development of the child; to establish a good relationship with the parents; strengthening cooperation between the local community and fostering good relationships between professionals.

“We had four aims: to ensure the optimal development of the child; establish a good relationship with the parents; strengthen the cooperation between the local community as well as between professionals.” Sure Start manager

With reference to the staff involved in delivering the programme, interviewees responded that every Sure Start centre has three permanent employees: the program director which usually holds a degree or diploma in a related field, experienced special education teachers, kindergarten teachers and health visitors or social workers. At least two employees have completed secondary education. There is no minimum level of education set for the third employee who is usually recruited from the local community. They are the principal connection between the centre and the communities. There are also some volunteers carrying out different responsibilities on a temporary basis.

Books and toys are available for children and they can spend time with their parents. Professional assistance is also provided if needed. The respondents explained that parenting classes are available as well as self help groups and personal consultations. Parents may seek work with provided assistance and use the IT services. The programme mainly addresses the child's complex needs through play by encouraging the will and aptitude for discovery. Staff also explained providing parents with consults, encouraging interaction and reflection on the needs of children. The staff respondents described organising activities to encourage and promote physical development, communication and emotional stimulation, independency, attention, memory, major motor skills and sense of direction.

“Parenting knowledge should be provided to the families, e.g. information on the developmental needs of the child and the appropriate ways to respond to these needs must be learnt just like non-violent communication, disciplining, listening to children and taking their views into consideration.” Sure Start manager

The location of Sure Start centres is decided upon by placing these near the intervention's target groups to make centres accessible. Each centre is equipped with a playroom for children, a consultation room for parents, a kitchen and a bathroom with a washing machine. Services are mostly provided in Sure Start Houses but events are also organised outside these -for example in kindergartens, schools or other public places.

Addressing potential inequalities in early child development and health

Regarding the potential to reduce inequalities in ECD, the participants explained that the program was developed to support children and their families to reduce health, social and education inequalities in the most deprived micro-regions in the country. It operates mainly in settlements where early education services are not available, focusing especially on 0-3 year olds. Many children are only enrolled for the compulsory 1 year pre-school program.

Sure Start was described by the respondents as a programme which addresses inequalities in child development and health by providing high quality services to groups with little or no access to these. The program is based on cooperation. Local social, healthcare, education, child welfare institutions and services collaborate and efforts are made to inform the public about the aim of the program encouraging all families-not only the most deprived-to participate.

Providing support for parents

Staff mentioned having developed a mentor program. Mentors visit Sure Start centres every month and provide supervision and consultation. Every centre adapts to local needs but high quality is ensured, according to respondents by following an existing common framework and values, training and regular supervision.

Domains of development

The program has a holistic and comprehensive approach, based on the child's developmental needs and rights. The centres involve parents as partners and encourage them to discover and use their own resources and capabilities. The programme takes into account the following areas of early childhood development: emotional, physical, cognitive and social domains. It provides stimulation through play and other activities.

“The methodology is based on peer support and formal and informal learning. Both the parents and children have the opportunity to meet and learn from each other” Sure Start manager

Staff described the most important aims of the program regarding ECD and health and some of its social determinants: providing early education opportunities to encourage cognitive development and improved emotional wellbeing and reducing regional poverty, deprivation and ethnic inequalities. By achieving this Sure Start staff aimed to improve life perspectives, future opportunities and outcomes.

“The Hungarian adaptation of the Sure Start Houses were developed in order to support children and their families to reduce health and social inequity in the most deprived micro-regions in the country.” Sure Start manager

Methods used to reach beneficiaries

The services' target groups, as described by the respondents, are mostly children age 0-3. They also accommodate children up to 5 years of age to ensure their school readiness (in Hungary this is the compulsory pre-school age 1 year prior to school. From September, 2015 it will be 3 years of age). Everyone from the local community can use the services but it provides activities with a special focus on children from poorer, deprived families to prevent developmental delay. Involvement of parents is a key point, the program is based on the active involvement of parents to understand and contribute to the optimal development of their children. As described by the staff, the programme provides support and information as well. One of the basic values of the programme is to not exclude anyone, as described by respondents. However, priority is given to children coming from deprived backgrounds.

The programme reached out to the most deprived by working closely with the local health visitors, child welfare services, kindergarten and other institutions in the local community. The interviewees explained that according to their experience, the program achieves reaching those who would benefit from it most; however there is still not enough information. In Budapest, in the 8th district, Sure Start centres are not able to accommodate for all the families. However in the small villages they described cooperating with different professionals in reaching out and felt they reached their target groups. The involvement of Roma and non-Roma families in the same activity can be difficult and reaching the most isolated groups was also described as difficult. Their service users are mostly Roma population therefore, Sure Start managers try to employ Roma staff members as well.

“According to our experience the Program can reach those who would benefit from it in most instances, however there is not enough information available.” Sure Start manager

Information on evaluations conducted

Informants explained that the programme is assessed by measuring the development of every child. An evaluation report is carried out every 6 months and shared with the parents. In 2009, 2010, 2011 and 2013 studies on the outcomes of the programme were published by the committee which was set up to evaluate it and in 2012 a civic report on children's chances was also published. According to the expert who designed the Hungarian adaptation of the UK Sure Start Program the documents suggest that the programme is a success and include information on the barriers and recommendations on how to overcome these. There was a plan to conduct a longitudinal comparative study to evaluate the impact of the regular attendance to Sure Start Houses comparing to children who were not taking part in the program. However, the informants explained that the government elected in 2010 decided to cancel it and according to the respondent, it would have been extremely important to demonstrate its usefulness as it would help to improve the services for families and young children all over the country, similarly to the UK evaluations. The programme manager interviewed explained that Sure Start undergoes an external evaluation every 2 years following a detailed indicator system. The evaluation assessed the socioeconomic context of the children and their families as well as children's development and success in kindergarten and schools.

“Yes, documentation is used to follow and measure the development of every child. It is filled out every half year and shared with the parents as well. These documents are evidences of the program's success.” Sure Start manager

With regards to the funding received by Sure Start, the respondents explained that during the first 3 years the programme received EU funding; during this period The Szécsény micro-regions received approximately 2 million Euros. During 2012 the situation was described by the informants as unsettled and they looked for private donors. However, from 2013 onwards, Sure Start has been funded by the Hungarian government.

Barriers or enablers

The respondents explained that when the programme was first implemented an essential obstacle was the fear of lack of sustainability because the government's commitment towards funding the programme was unclear. However, Sure Start centres are now part of the national inclusion and tackling child poverty program.

According to the interviewees, some parents attending the centre are apprehensive about facing or being confronted by their own problems and fear being judged by others. They feel they lack skills and might be humiliated or fear their children might be taken away. In Hungary there is very little tradition of seeking help and accepting support as quite often there is a judgemental negative approach towards it. In these cases the staff from Sure Start access parents via friends, grandparents or other community members to help them gain confidence in the programme.

Further barriers described by the interviewees referred to the high resource demand and to the population's needs in the micro-regions and explained that intersectoral professional workshops were carried out every month to overcome these.

B: Sure Start Hungary focus groups with parents

Socioeconomic context of the area and users receiving the service

During the group discussion, the families participating shared their feelings of helplessness prior to the opening of the Sure Start House. They felt "alone" with their problems and ignored by public services. Participants tried many possibilities in searching for an appropriate place to spend quality time with their children and other mothers/parents.

Addressing potential inequalities in early child development and health

The participants agreed on the important role of well-designed and properly managed interventions but questioned the quality of the public services in their area. A detailed discussion explaining how the Sure Start centre has changed their circumstances evolved among parents as it has given them hope and opportunities in raising their children in a better way. They referred specifically to the usefulness of the play group as well as having access to the washing facilities, computers, child care and snacks provided for their children. The friendly and supportive non-judgmental attitudes of Sure Start professionals were mentioned on many occasions.

Parents agreed that in most cases school failure is a consequence of life circumstances within the family and in the wider environment, stressing the importance of early childhood development services. They also agreed on the importance of community support during pregnancy and the first years of the child because mothers often feel left alone and isolated during this period of time. Two mothers from the focus group who regularly visit the Sure Start Centre explained that one of them has a child with special needs and is satisfied with

the skill and competence in development that the program offers. The other mother described simply enjoying being part of a diverse group and helping other mothers.

Barriers and enablers

Some of the parents had visited Sure Start Houses before but the majority felt that they were not the target group of the service and that it was aimed at children belonging to “poor families”.

Universal Health Visitor System

A: Individual interviews with health visitors

Socioeconomic context of the area and users receiving the service

The respondents explained that in the more deprived and complex areas health visitors are responsible for more than 400 children. The unemployment rate in these areas is two or three times higher than the country average and approximately every third child lives in a home where everyone is unemployed. Furthermore, the interviewees explained that education outcomes are poor but community bonds are strong.

“The unemployment rate is two or sometimes three times higher than the country average and around every third child is living in a family where no one has a job. The education outcomes are poor. Community relations are strong.” Health visitor

Intervention delivered and objectives

Regarding the description of the service, the participants explained that it is a universal programme providing home care for young children to promote prenatal health and the healthy development of infants and toddlers as well as supporting and providing advice for mothers. The health visitor’s principal aims are: prevention, early intervention and referral to other services if needed. Ideally one health visitor carries out a follow-up of the child on a long-term basis.

“Health visitation’s aims are: prevention, early intervention and referral to other services if needed.” Health visitor

The respondents explained that as health visitors they offer advice and carry out consults, counselling (breastfeeding, care of the infants and children, prevention of unwanted pregnancy, recognition of child abuse and neglect, maternal depression, etc.), medical examination of new-borns and toddlers, immunisation, compulsory childhood vaccination, recognition of emotional or other type of abuses and neglect. From 2013 onwards, cervical cancer screening has also been introduced.

Most of the work is carried out in the family home following an individual care plan which is developed together with the parents. The respondents explained that the service also counts with and outpatient clinic for families and health visitors also have regular visiting hours in Sure Start centres. These visits-as described by the respondents-provide the opportunity to visit more mothers and children together, travel less and reach more people, especially those who are hard to reach. The health visitors interviewed also explained that they visited

kindergartens every 3 months in their district to assess the facilities, cleanliness, etc. and to meet with the children in a group situation.

Addressing potential inequalities in early child development and health

When responding to how the service addresses inequalities in ECD, the respondents explained that the health visitors provide health and development services directly to family homes. It aims to promote the physical, mental and social well-being of families and their children and help improve parenting abilities by assessing children's needs and preventing neglect and abuse.

Providing support for families

The interviewees described providing a wide range of services for every mother and child, depending on their needs. Families with higher needs receive specific interventions that respondents described as having the potential to reduce inequalities in children. Health visitors follow the development of the child ensuring their health by providing all the necessary preventive measures. The respondents were of the opinion that early recognition of special needs plays an important role in reducing inequalities.

Domains of child development

The home visitor's programme was described by the respondents as a service which focuses on all dimensions of child development.

"Home visitation includes all dimensions of child development: physical and emotional as well. The recent requirements to detect and report child abuse and some forms of neglect is causing a lot of concerns as our training has not been focusing on this areas and communication with the families is not always easy." Health visitor

Methods used to reach beneficiaries

Respondents described it as a universal service covering the entire country. Service users are expecting women, mothers with young children and children aged 0-6 or older if they have a disability or special needs. The respondents felt that the service reaches the intended users; however homeless or non-registered families, among others, are hard to reach.

"It is a universal service covering the entire country. Service users are expecting women, mothers with young children, infants, toddlers, children aged between 0-6 and older children with disabilities or special needs." Health visitor

Information on evaluations conducted

The respondents stated having no information on outcomes, but local services have collected basic data on the interventions (number of contacts, number and age of beneficiaries, services utilised, etc.). There is a periodical published by the Association of Health Visitors (MAVE) and many unpublished thesis have been written at master's and PhD levels so far but the respondents are not aware of any research on an overall evaluation.

The service is funded by the central government's budget and the local governments. The interviewees explained that the health visitor's salary is very low despite the fact that they have received 4 years of training in college.

Barriers encountered when implementing the intervention or service

The respondents referred to the health visitor's low salaries and the fact that caseloads are high and that the administrative paperwork takes longer than the visits themselves. An additional barrier is that a growing number of cases are being taken on by GPs with no specialised training on children's health. In many instances the health visitors interviewed felt they did not have sufficient information regarding some of the children. For example parents may not have immunisation or previous hospitalisation records which makes providing health care more difficult for the professionals delivering the service.

"The caseloads are high and the administration of the visits takes longer time than the visits themselves." Health visitor

The health visitors interviewed referred to the barriers sometimes encountered when visiting wealthy and/or highly educated families because they sometimes do not agree with the importance of the work carried out by the health visitors and/or they may sometimes have different views on health care. They sometimes prefer different approaches such as alternative medicine, homeopathy or not vaccinating their children, for example. The respondents explained that some parents feel they know more about their children's health than the professionals who visit. However, the interviewees explained that some health visitors still represent old fashioned principles or do not have the required communication skills and can be judgemental. Establishing trusting relationships is also described as difficult by the interviewees. They explained that in order to do so, they identify the key carer within the family and earn their trust. Staff found it difficult to work with some families because they were wary of professionals and workers from the public sphere.

"People on the other hand are often irritated, angry and sometimes aggressive many of us are scared, try to avoid any conflict. They blame us for the lack of services, free medication, etc. it is getting very hard." Health visitor

B: Focus group with Universal Health Visitor System and Sure Start parents

Socioeconomic context of the area and users receiving the service

Due to the very limited opportunities and the lack of tradition of community based self-help or any kind of volunteering, most mothers struggle alone according to respondents. There is a widespread belief in Hungary that mothers should stay at home with their children until at least 3 years of age.

Addressing potential inequalities in early child development and health

Most parents in the group were highly satisfied with the services offered by their health visitors. They described having a trusting and close relationship with their health visitors. Parents were also grateful because visitors could be reached any time when they needed advice. However some parents had had negative experiences in the past with health visitors. For example, they did not offer the help they needed, only carried out the administrative paperwork during visits or were not approachable.

Barriers

Some participants expressed feeling reticent about talking to professionals employed by the government and letting them intervene in their private life. They felt strongly that it is a patronising program threatening the autonomy of their families while accepting that many families need it if carried out accordingly. Some of the parents felt it did not meet their expectations and were not satisfied with their health visitor's attitudes. Some parents felt it was an unnecessary intervention as when parents need help they prefer to ask their own families, experienced women in their community, friends, or a professional they trust. Books and the internet are also other sources of information parents described as useful. During the discussion some participants realised that they had the same health visitor but had different experiences with him/her. It was commonly acknowledged that there are many controversial discussions regarding child care and many different messages on the "best" ways of taking good care of children. They were of the opinion that health visitors lack information or are often too busy and do not have time to listen to and discuss the more complex issues. All the participants agreed that the role of the paediatrician is crucial.

Theotokos Centre

A: Individual interviews with mothers

Socioeconomic context of the area and users receiving the service

The mothers described coming from very deprived backgrounds. They live/d in shelters or on the street and have little or no family support and have chronic illnesses. They have suffered abuse from family members and/or their husbands. Most did not have a stable job, did not have sufficient income and could not afford accommodation for their family. Maternal grandparents were described as being involved in raising the children and offering economic and emotional support to families.

Addressing potential inequalities in early child development and health

The mothers explained that the Centre finances their children's kindergarten which in their opinion contributes to their education. They expressed liking the centre and its kind staff and felt the children enjoyed attending it.

Methods used to reach beneficiaries

Some were referred to the Theotokos Centre by child protection services and other similar social services.

B: Theotokos Centre individual interviews with staff

Socioeconomic context of the area and users receiving the service

According to employees' responses, in most cases, beneficiaries are sent to the centre by the General Department of Social Assistance and Child Protection. Most of the mothers grew up in a children's shelter run by social services within Cluj-Napoca City Hall and by other social service providers.

"Families who have high socio-economic difficulties, which face a very strong marginalization who are extremely disadvantaged in several aspects."

Intervention delivered and objectives

Charities and similar organisations refer single mothers and children, because according to respondents, there is only one centre in the city which can only accommodate mothers with babies under 6 months. Some of the families came to the centre of their own accord. In the autumn of 2013 a vast action for identifying children who were not enrolled in the state education system was carried out and according to respondents, some of these children now benefit from its services. However, there are situations where need exceeds the capacity of the centre, especially the day-care centre which is limited to ten children. Due to limited space and resources the day-care centre can only accept 30% of the cases referred to them. The eligible families were registered on a "waiting list" or sign-posted to other institutions that provide support or food supplies during difficult moments. There are specific working tools (individualised protection plan) and ongoing activities with specific goals and aims (each child has a weekly activity sheet). However, there is a certain focus on involving and empowering parents regarding their children.

"Project objectives are: (1) improving the quality of life for 30 children from single parent families aged 0-6 years who are at risk of maternal abandonment; (2) development of employability skills in society for 55 members of single-parent families...." Head of the Theotokos centre

Respondents explained that the day centre for children offers full free nursery services from 6am to 6pm, 5 days a week. The program was designed to hold a maximum of 10 children, and the centre works mostly at its maximum capacity. Children benefit from three meals in the centre; they can sleep in comfortable and age appropriate beds and play with stimulating toys. A trained person supervises children and guides their play. The staff explained that they know how to comfort children who often seem anxious and frustrated. The centre also offers counselling and support for parents (usually mothers). As described by the respondent workers, the activities are designed to ensure the preservation of the family unit, to develop the parental capacities of the mothers, and to help them overcome critical situations which could cause the child's separation from the family. The program reinforces mother's attachment to their children, considered very important during the first three years of their lives. The "support group" activity takes place weekly and a large number of beneficiaries are encouraged to take part. A fixed programme of meetings with mothers and a set of topics to be discussed at each meeting are established. The meetings are supervised by the project coordinator, the psychologist and the social worker. Sometimes, depending on the themes of the topics chosen, the doctor who monitors the health of children, or the priest responsible for spiritual counselling are invited to attend the meetings.

"The Centre wasn't built by a particular model, the needs and problems of the community have called for the establishment of the Centre and the development of related services." Head of the Theotokos centre

Addressing potential inequalities in early child development and health

Employees' feedback underlined the importance of services provided in order to help reducing potential inequalities in early development among children who come from disadvantaged backgrounds by offering them access to quality early education. The employees explained that children are cognitively stimulated in the centre during the 10-12 hours spent with trained staff; their health is maintained at an optimum level; they receive care, food, attention and everything they need. Moreover, parents and caretakers are

involved in various activities that aim at necessary skills for social and professional integration and leading a responsible, self-supporting life. According to the employees, the intervention is not built on any particular model but it leads to positive results.

“The center has effective tools...responsibility for ensuring the growth and development of children rests primarily parents, they had a duty to exercise their rights and fulfill their obligations to the child taking into account the interests of its priority.” Head of the Theotokos centre

Providing support for families

The employees explained that in terms of social work, a personal case chart is completed with information regarding the mother, the assistance agreement between the two parties, a personalized intervention plan, depending on the identified issues and needs, a psychological evaluation sheet, a counselling individualised plan, an appointments' diary - recording progress-, and a family case study. Regarding counselling and supporting the child, an initial assessment is carried out with several tests; the intervention plan is devised, as well as a monthly assessment plan, activities chart, and the medical report. After the initial assessment, the case monitoring starts, as well as periodic reassessment ending with the final evaluation. All these tools offer relevant information about the family situation from all points of view, about the development of the child and the mother or their capacities performing different tasks and duties.

“The headquarters are located in an easily accessible by public transport and as shown is located in a quiet area.” Head of the Theotokos centre

Domains of child development

The respondent referred to the trained personnel hired in order to take into account various dimensions of child development (for example, early childhood cognitive development). The team is multidisciplinary, composed by a coordinator, a manager, a psychologist, a social worker, a supervisor (part-time), four early childhood educators, a doctor (part-time) and a priest. There is an emphasis on verbal development: verbalizing activities and storytelling. Singing and music is part of the program, as well as movement, coordination and outdoor free play.

Information on evaluations conducted

There are different types of internal evaluations such as weekly meetings with team members to monitor each case to see whether the objectives have been achieved in the Individualised Protection Plan, for example. The development of children is also monitored, by the psychologist and the speech therapist and elaborate individual intervention plans if necessary. According to some employees the children who did not show progress were often not attending the programme regularly. During the 9 years of functioning, the program has assisted more than 200 mothers and their children. There is always a waiting list for the available places, and selection is made according to the risks faced by mothers.

The main sources of funding were: the state, the City Council of Cluj-Napoca, the U.S. Orthodox Christian Mission Center, campaigns performed in schools, donations from individuals and businesses. In addition to various internal and external sponsors, campaigns and self-financing was achieved by small amounts of money from the sale of handmade items created by our studio.

“But to have it exactly as you see it now major investment was essential to Orthodox Christian Missionary Center of America.” Social worker

Barriers encountered when delivering the service

Employees mentioned an obstacle in the intervention being the limited space capacity because it cannot provide services to new beneficiaries or to a larger number of children. In the beginning the centre was unknown to the business community or other potential funders however, at present a large part of their work is supported by the goodwill of many people from the community of Cluj. The employees also referred to some initial reluctance of the mothers to follow the advice provided, mainly due to the change of lifestyle habits. However, previous experience of the staff working in the centre helped them to successfully overcome this difficulty and build trusting relationships with the mothers.

C: Focus group with mothers attending the Theotokos centre

Socioeconomic background of the beneficiaries

Some of the mothers explained that they lived in an Emergency Center and some had also grown up in a children's home. Most had to live in centres or shelters because they did not have sufficient money to pay the rent. They have little or no support from their families or from farther of the child. Most of the mothers had their children at age 21. They described not having very trustworthy relationships with the children's parents and not relying on them as carers. Mothers who lived with their family described living in overcrowded conditions and having to look after other sick members of the family.

"I got a degree, but I could not work in that direction because the girl was too small and I had nobody to stay with her. Now I work as an assistant cook at an organization -Prison Fellowship." Theotokos centre mother

"Me and my older sister are the sole support of the family and for me the biggest support was and remains my mother, even if she's so sick." Theotokos centre mother

Intervention delivered and objectives

Mothers expressed liking the building but were concerned about the lack of space and other families not being able to access the centre's services. Mothers explained not paying any fees and not knowing how the centre is funded. Some mothers did explain having some knowledge on items being made by the staff and sold during festivities to raise money.

"Now, we found an organization, which pays our rent and so we live all together in a pretty house." Theotokos centre mother

Addressing potential inequalities in early child development and health

Mothers referred to their children receiving an education and the centre being in good conditions. One of the mothers explained seeing her daughter learning to count and identify colours and singing songs. The mother explained that her daughter was not able to attend for a year due to the mother's absence from the country and during this period the daughter forgot what she had learned and her progress stagnated. Other mothers highlighted the good hygienic conditions of the premises and that staff looked after the children's overall wellbeing.

"A. tells me and shows me a lot of things. In the Center, he learned a lot of good things; he knows a lot of words and many different songs. I like to go out and play with my kids in the park where we sing and we have fun." Theotokos centre mother

“My children are well and I love them very much. With my little baby, I was coming here to the Center since he had 3-4 months I bring him every day because I learned the way on my own.”

Methods used to contact beneficiaries

Some mothers described being referred to the Theotokos centre by child protection services. The centre helped mothers by providing financial resources and paying for their children's preschool fees.

“Yes, the Center helps us as they could... First, financial and then with a kind word, an advice and so on. Also we received food once a month and I don't know what I would have done without their help ...” Theotokos centre mother

Information on evaluations conducted

One mother explained having attended a meeting with attendants from the finance department and felt that they were optimistic about the centre's achievements.

“My youngest daughter came here where she is very well. The children are clean, they receive attention, somebody take care of them and here are specialized personnel which deal with them.” Theotokos centre mother

Barriers and enablers

Mothers referred to the limited space and other families not being able to make use of the services. Most of the mothers explained that they used tram season passes to reach the centre but could not bring some of their children along to some of the meetings as they did not have enough money to buy their ticket. In addition children were still accepted at the centre even if they were ill and this made some of the other children ill as well.

“But sometimes he gets sick because there are a lot of children in the same place and take the ill each other. Three weeks ago he was very ill with bronchitis, conjunctivitis and I took him home.” Theotokos centre mother

Discussion

Most programmes were delivered in areas with low levels of service provision, the exception to this was Netzwerk Familie. The majority of families and children were from deprived backgrounds. Programmes that were not universal reached beneficiaries using a variety of methods. These included contact in hospitals after delivery, through social services, community groups and relatives. Only the universal health visitor programme delivered in Hungary began in the ante-natal period. The objectives of the programmes were to enhance children's health and development. These were delivered by staff members from the health, psychology and social sectors. Some-Toybox, Sure Start and the Theotokos centre-provided activities to stimulate children's learning through structured play and provided support and assistance for parents. In the three programmes the parents were actively involved in activities and respondents referred to long-lasting trust based relationships between staff and parents as one of the basis for the success of these programmes. Staff and users generally gave very similar accounts of the intervention through their experiences, and parents expressed a high level of satisfaction. The exception to this was the health visitor programme where the two groups of informants put forward a slightly different view regarding the main barriers to implementation. While both groups agreed that limited available resources and space were a barrier, staff identified the reluctance of parents to attend some of the services and parents highlighted a bureaucratic approach by staff. The available evaluations were based on monitoring indicators and measuring output and process assessments. No long term evaluation or comparison with a control group had been carried out.

Representativeness of case studies

This report illustrates early years initiatives delivered in Romania, Hungary, Austria and in the UK. Ensuring a sufficient range of countries to reflect the different contexts in Europe was one of the selection criteria for interventions included in this report. To reflect evidence of early years interventions carried out in countries which were not represented in the systematic review of early years interventions aimed at reducing inequalities (19). Respondents from these countries described interventions being delivered within a context of insufficient children's social and health service provision. The interventions were delivered, in part, to bridge the gap of insufficient services to families mostly from deprived backgrounds. Programmes were open to the community; however, activities had a special focus on children and families with disadvantages, with the exception of the universal health visitor programme, which targeted the entire population. Similarly the systematic review carried out within the ECD strand of Drivers (19), found that the majority of interventions identified were targeted at children living in deprived areas. The interventions were aimed at reducing social inequalities in children's health and development but not at levelling the social gradient in health (20).

Common findings

The objectives of the programmes selected for this report were to enhance children's development and health, to provide a space for parents and children and give parents support and assistance and delivering activities and structured play. The programmes were

identified from within a sample of interventions provided by third party organisations collaborating with the Drivers project and do not necessarily represent all the programmes being delivered across Europe. Nevertheless, the results show similarities with the main findings in the systematic review of interventions (19). Those that were most effective aimed to improve parenting capacities and some had additional components such as: day-care provision, improving housing conditions and speech or psychological therapies. Programmes offered intensive support, health information and home visits using a psycho-educational approach and aimed at developing parent's skills. The interventions identified in this study also aimed to provide access to quality early education to reduce potential inequalities during the early development of children, especially for those who come from disadvantaged backgrounds. The evidence from the review also showed that programmes which included prenatal visits had better outcomes than those starting after birth and those beginning during the first stages of life in turn had more favourable results than those beginning when the child was older (19). However, among the case studies described in this report, only the health visitor programme provided prenatal care.

Targeting capacity building

It was mentioned by the majority of staff that delivering an intervention -aimed at young children and their parents- effectively, entails recognising the knowledge and capacities of parents. The programmes were aimed at strengthening parenting abilities to assist in their children's learning and development and most adapted to and understood the families' circumstances. Interventions involved parents through play and were flexible to ensure parents' participation. Programmes were delivered by staff from different disciplines, some such as Family Network were provided by a network of professionals. Staff saw providing a comprehensive range of services with the potential to reduce inequalities in children -to every mother and child, important. Similarly, other studies illustrated how parenting activities across income groups and the social gradient (4) fostered through ECD programmes were not limited to cognitive gains, but also included physical, social, and emotional gains, all of which are determinants of health over the life course (21). Further evidence also described that parenting programmes offer valuable opportunities to positively influence children's health and create resilience (12). However, while focusing on parenting is important, it is also necessary to address the conditions of daily life which make positive parenting difficult. This requires policies aimed at children through an explicit, multi-dimensional and integrated strategy (22) and investment in reducing child poverty and improved living conditions (23). An important aspect of early years programmes is the quality of relationships between the deliverer and the recipient as well as ensuring that the recipients who meet the eligibility criteria receive programmes relevant to their needs. Evidence from a study reviewing the literature on inequalities in ECD and health, which forms part of the Drivers project, showed that most social factors, at both the neighbourhood and household levels, influenced early childhood health and development extending across a wide range of adverse health and developmental outcomes in early life (24).

Involving parents

Aims such as encouraging and supporting parents/families to become involved in community activities by engaging with them through children's programmes were also important

components in most interventions. Similarly, LicketyLeap - an interactive theatre play for children involving action learning, where children participated in the performance - was designed to encourage children to develop new skills and learn through multiple reactions to imaginary situations (25). The intervention, delivered by the early years service LicketySpit, reinforced learning experience and aimed to build on their confidence by integrating Applied Theatre practices (26), fostering imaginative play among children and engaging with their significant adults. The objectives of the intervention were to fortify parent and child attachment, confidence, self-esteem and children's capacity to flourish. LicketyLeap was delivered in Scotland, in deprived areas within North/South Edinburgh, East Lothian, North/South Glasgow and Fife. It engaged with hard to reach families delivering two half-day sessions led by two specialist actor pedagogues. Target groups were children 3-5 years old. Parents/carers attended the second half of the follow up session to hear about the project and see some live performances performed by children. The programme had been delivered to 29 nurseries attended by 1510 children in multiply deprived areas. A mixed methods evaluation showed an increase in children's confidence, improve their social skills their resilience and ability to problem solve (4, 5).

Barriers in implementing interventions

Beneficiaries referred to fear of being judged as a barrier as well as some reluctance towards the programmes. In addition, insufficient capacity and resources limited the number of children, families and /or mother attending the centres. Funding was described as a very important obstacle by staff working in programmes which were not funded by the government. Stigmatisation of users and/or showing some mistrust towards service providers and programmes may be customary within a prevailing culture of low levels of service provision. Furthermore, the gap in service provision was accompanied in some areas by a reduced use of existing infrastructures and lack of intersectoral collaboration.

Other interventions examined

The Ruchazie Family Centre and North Ayrshire early years programme in Scotland are further examples of interventions providing support and activities for parents and children. The Ruchazie Centre delivers integrated early childhood education and care, outreach support for parents and direct work with families and children. It encourages mutual support among families and develops a sense of cohesion in the community. Emotional support is provided in a safe environment by qualified staff. An independent evaluation of the work of the Centre was carried out in 2006 (27). Findings indicated that while 97 percent of children were assessed as receiving poor parenting on referral, by age three, 77 percent (17 out of 22) were no longer considered to be at risk and all children had improved relationships and attachment with their parents despite 67 percent having poor attachment at the time of referral.

The North Ayrshire Council piloted the inclusion of at risk two year olds in their pre-school education provision, normally available to three and four year olds. The programme included flexible attendance patterns and a curricular focus on 'positive learning experiences'. These positive experiences were provided by building relationships with children and parents, supporting children's sensory experiences, developing their language and creativity,

promoting their physical development and encouraging their enjoyment of their environment. An evaluation of the programme was carried out during the second year of the pilot between August 2007 and June 2008 (28). Parents of vulnerable children in the extended pilot programme showed improved parenting capacity compared to comparison group parents. Children in the pilot programme showed improved developmental outcomes but their progress was not significantly different from that of comparison group children. Staff reported new learning on their part that would inform future practice with pre-school children.

Comparison with other analysis

An analysis of inequalities across cohorts from 12 European countries, which also forms part of the Drivers project (8), illustrated that poor health is greater amongst children of mothers with low education. Therefore interrupting intergenerational transmission of inequalities is an important consideration (5). Longitudinal birth cohort studies, such as these, provide data which can help monitor health inequalities and the impact of early years interventions. A further example of a cohort study is the GUS longitudinal birth cohort commissioned by the Scottish Government in 2003 which collected data from three child cohorts and included approximately 14,000 children. This longitudinal research project aimed at tracking the lives of a cohort of Scottish children from the early years, through childhood and into adulthood. Focusing initially on a cohort of 5,217 children aged 0-1 years old (birth cohort) and a cohort of 2,859 children aged 2-3 years old (child cohort), the first wave of fieldwork began in April 2005. Among the 1,800 variables collected, the following questions and measurements were included: the children's birth weight, their experience of long-term health problems, accidents, poor psychosocial health, reported behaviour difficulties and problems with cognitive or language development. The risk factors for poor health were: maternal smoking, maternal health, children's physical activity levels and their diet (including whether they were breastfed). These outcomes and risk factors were explored in a study by the Scottish Government in relation to area deprivation, household income, and household socio-economic classification. They showed that children whose mothers smoked at some point in their early years, most were exposed to this on a prolonged rather than temporary basis. The more disadvantaged households faced a double burden in their experience of health inequalities as both the children and adults within them were at greater risk of negative outcomes (30).

Comparison with programmes outside Europe

This case studies report focuses on interventions delivered within Europe. In a like manner, in the early years Drivers systematic review (18), all but 1 of the interventions-delivered in Sweden-were carried out in the United Kingdom and the Republic of Ireland. However, examples of early years programmes outside Europe have been well documented: "The Perry Preschool Project" delivered during 1962–1967 and the "High/Scope Preschool Curriculum Study" (1967–1970) which showed positive outcomes for test scores, high school completion, lower arrests and criminality, teenage pregnancies and higher home ownerships. The "Carolina Abecedarian Project" (1972–1985) and the "Syracuse Family Development Research Program" (1969–1975) had an impact on improving development and intellectual quotient scores (6, 31). The Nurse Partnership, also, has shown long-term beneficial effects in the USA. It was evaluated by three RCTs and children in the intervention

group showed higher reading and mathematics tests scores. Long term evaluations showed children had fewer sexual partners, less smoking and drinking and ingestion of dangerous substances. Injuries and abuse were also reduced as was criminality during later years (32). “Sure Start” Australia (33) showed very little detectable difference between the intervention and Start-to-be communities. “Head Start” in the USA (34) improved conduct problems and noncompliance (35, 36).

Strengths and limitations of this study

The study had several limitations, the interviews and case studies were performed by third parties in each country. This may have contributed to differences in carrying out of interviews and focus groups to differ across interventions. The fact that third parties performed the interviews and focus groups was also a strength as these were carried out in their native language and in the majority of instances they were involved in delivering the intervention or had close contact with managers and therefore there was a previously established trustworthy relationship. Third parties provided University College London with summaries of the notes taken and recordings of sessions. These differed in length and detail and were at different levels of interpretation. The limitations however were mitigated by the fact that UCL provided a common template and guide for third parties to carry out the case studies. These included guidance on the methods to be used for the individual interviews, focus groups and on providing socioeconomic indicators. There was no consistency in the types of assessment or evaluation carried out in the case studies. Informants described periodic monitoring, assessing children’s performance or collecting data on the delivery of interventions, however, there was a lack of quantifiable data to assess whether programmes had a long-term impact on health and development. The interventions selected in the Drivers early years systematic review (8) had undergone an external formal evaluation and their main findings were that interventions with better outcomes and higher level of evidence combined workshops and educational programmes for both parents and children beginning during early pregnancy and included home visits by specialised staff. In the future, evaluation of early years programmes would allow comparison of the outcomes of programmes delivered in families’ homes or centres. For example, the systematic review on early years interventions found that interventions with better outcomes combined both.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Establishing long lasting trust based relationships was described as an enabler in the delivery of programmes and services, especially to socially isolated or hard to reach families and children. Programmes described as being successful, in providing support and building on parent's capacities, delivered flexible services with activities carried out by multidisciplinary teams. Staff stressed the importance of adapting to and understanding the families' circumstances and involving parents as it contributed towards empowering parents and developing their educational skills. According to respondents, this had a positive effect on children. By providing a comprehensive network of professionals across disciplines, programmes aimed to cover the additional needs not met by standard ECD social and health service provision in their areas.

Recommendations

1. It is important to provide access to a comprehensive range of quality early year services to reduce inequalities during the early development of children, especially for those who come from disadvantaged backgrounds.
2. Services should be tailored to social and economic need.
3. It is important to recognise the knowledge and capacities of parents if interventions aimed at young children and their parents are to be delivered effectively.
4. To ensure that parents have an active involvement in early years programmes, they should receive support and information to understand and contribute to the optimal development of their children.
5. Parents should be empowered to develop their own educational skills thus strengthening their ability to assist in their children's learning and development.
6. Existing ECD institutions and structures should be strengthened to promote cross-sector working between the social, education and health sectors.
7. The recognition, representation and funding of ECD in all areas of work and policy should be enhanced through high-level leadership. This includes promoting support for children who are deprived or vulnerable.
8. Programmes delivered in families' homes and in accessible centres should be evaluated so as to compare outcomes when using one or other of these settings or a combination of the two.

REFERENCES

1. 7th Framework Programme: Health Gradient-Drivers for Health Equity. 2012–2014 [<http://health-gradient.eu/>].
2. Dyson A, Hertzman C, Roberts H, Tunstill J, Vaghri Z: Childhood development, education and health inequalities, Task group report to the Strategic Review of Health Inequalities in England Post 2010 (Marmot Review). London: University College London; 2009.
3. Hertzman C, Boyce T. How experience gets under the skin to create gradients in developmental health. *Annual Review of Public Health*. 2010;31(Journal Article):329-47 3p following 47.
4. Kelly Y, Sacker A, Del Bono E, Francesconi M, Marmot M. What role for the home learning environment and parenting in reducing the socioeconomic gradient in child development? Findings from the Millennium Cohort Study. *Archives of Disease in Childhood*. 2011;96(9):832-7.
5. Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, Geddes I: Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post-2010. London: Marmot Review Team; 2010.
6. Geddes R, Haw S, Frank J: Interventions for Promoting Early Child Development for Health: An Environmental Scan with Special Reference to Scotland. Edinburgh: Scottish Collaboration for Public Health Research and Policy; 2010.
7. Geddes R, Frank J, Haw S: A rapid review of key strategies to improve the cognitive and social development of children in Scotland. *Health Pol* 2011, 101:20–28.
8. Marmot M, Commission on the Social Determinants of Health: Achieving health equity: from root causes to fair outcomes. *Lancet* 2007, 370(9593):1153–1163.
9. Rough E, Goldblatt P, Marmot M, Nathansona V: Chapter 3: Inequalities in Child Health. In *Growing Up in the UK: Ensuring a Healthy Future for our Children*. Edited by BMA Science and Education department and the Board of Science UK. 2013:37–56.
10. Hertzman C, Wiens M: Child development and long-term outcomes: a population health perspective and summary of successful interventions. *Soc Sci Med* 1996, 43:1083–1096.
11. Maggi S, Irwin LJ, Siddiqi A, Hertzman C: The social determinants of early child development: an overview. *J Paediatr Child Health* 2010, 46(11):627–635.
12. McAvoy H, Purdy J, Mac Evilly C, Sneddon H: Prevention and Early Intervention in Children and Young People's Services. Dublin: Child Health and Development; 2013.
13. Maxwell JA. Qualitative research design. An interactive approach. Thousand Oaks, California: SAGE; 2005.
14. International Labour Organisation, ILOSTAT Database. URL: http://www.ilo.org/ilostat/faces/statisticaldata?adf.ctrlstate=14d79srate_418&clean=true&afrLoop=891556862163637 accessed 12/12/2014
15. Organisation for Economic Co-operation and Development, Families and children database. URL: <http://www.oecd.org/els/family/database.htm> Accessed: 15/12/2014
16. European Commission. Employment, social affairs and inclusion publications catalouge. *Social Europe – Many ways, one objective - Report of the Social Protection Committee* (2013). URL: file:///ad.ucl.ac.uk/slms/home4/rmjdm/Contacts/2013_SPC_Annual_report_Accessible_v1.0.pdf

Accessed: 16/12/2014.

17. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19(6):349-57.
18. Mays N, Pope C. Qualitative research in health care - Assessing quality in qualitative research. *BMJ*. 2000;320(7226):50-2.
19. Morrison J, Pikhart H, Ruiz M, Goldblatt P. Systematic review of parenting interventions in European countries aiming to reduce social inequalities in children's health and development. *BMC Public Health*. 2014;In press.
20. World Health Organisation: Review of Social Determinants and the Health Divide in the WHO European Region. Copenhagen: Institute of Health Equity, University College London and the WHO Regional Office for Europe; 2013.
21. Irwin LG, Siddiqi A, Hertzman C: Early child development: A powerful equalizer final report for the world health organization's commission on the social determinants of health. Geneva: 2009. Retrieved from World Health Organization website: http://www.who.int/social_determinants/themes/earlychilddevelopment/en/.
22. Hoelscher P: What works? Preventing and reducing child poverty in Europe. *Eur J Soc Secur* 2006, 8(3):257-277.
23. Commission on Social Determinants of Health, WHO: Closing the Gap in a Generation. Health Equity Through Action on the Social Determinants of Health. FINAL REPORT 2011. [http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf].
24. Pillas D, Marmot M, Naicker K, Goldblatt P, Morrison J, Pikhart H. Social inequalities in early childhood health and development: a European-wide systematic review. *Pediatric Research*. 2014. Epub 2014/08/15.4
25. Virginia Radcliffe L. 'The Adventures of LicketyLeap: Transforming lives - the possibilities of theatre' Edinburgh, UK: Allander; 2013.
26. Knight S. Leaping into Ourselves: A study into the layers of engagement made by early years children through LicketySpit's immersive theatre project, LicketyLeap' Glasgow: 2011.
27. Walker M. Another kind of social work? Evaluation of Quarriers. Family Resource Centre. Bridge of Weir: 2006.
28. Woolfson L. Evaluation of The Extended Pre-School Provision for Vulnerable Two Year Olds Pilot Programme Final Report. 2008.
29. Ruiz M, Goldblatt P, Morrison J, Kukla L, Švancara J, Riitta-Jarvelin M, Taanila A, Saurel-Cubizolles MJ, Lioret S, Bakoula C, Veltsista A, Porta D, Forastiere F, van Eijsden M, Vrijkotte T, Eggesbø M, White RA, Barros H, Correia S, Vrijheid M, Torrent M, Rebagliato M, Larrañaga I, Ludvigsson J, Olsen Faresjö A, Hryhorczuk A, Antipkin Y, Marmot M, Pikhart H. Maternal education and early childhood health: A DRIVERS meta-analysis in 12 European cohorts. In progress.
30. The Scottish Government. Growing Up in Scotland: Health inequalities in the early years 2010 [26-11-2014]. Available from: <http://www.scotland.gov.uk/Publications/2010/04/21132105/1>.
31. Wise S, Webster E, Sanson A: The Efficacy of Early Childhood Interventions. In AIFS Research Report No 14. Melbourne: The Australian Institute of Family Studies; 2005
32. Institute for the Study of Children, Families and Social Issues at Birkbeck, University of London: Formative Evaluation of the First Phase of the Group-based Family Nurse Partnership Programme. London: Department of Health; 2012
33. Katz I, Valentine K: Lessons for Australia from the Sure Start Programme. Sydney: Social Policy Research Centre University of New South Wales; 2009.

34. Hutchings J, Gardner F, Bywater T, Daley D, Whitaker C, Jones K, Eames C, Edwards RT: Parenting intervention in sure start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial. *BMJ* 2007, 334(7595):678.
35. Webster-Stratton C, Reid MJ, Hammond M. Preventing conduct problems, promoting social competence: a parent and teacher training partnership in head start. *Journal of clinical child psychology*. 2001;30(3):283-302.
36. Webster-Stratton C. Preventing conduct problems in Head Start children: strengthening parenting competencies. *Journal of consulting and clinical psychology*. 1998;66(5):715-30.

ANNEXES

Annex 1. Framework for case studies on interventions to reduce inequalities in early child development and health. WP6 Drivers for health equity.

Could you kindly answer to the following questions below providing as much detail as possible regarding the service carried out to reduce inequities in child development? Please use more space if needed.

1. Please describe the service you are delivering.

Include, where relevant, the general and specific objectives of the service and who is intended to benefit from it and the target population. Describe the type of premises in which it is delivered and where it is delivered, for example in specific neighbourhoods or other types of local areas. Indicate how the service is delivered (e.g.: by professionals or volunteers).

2. Could you give detail of specific activities and interventions?

Include descriptions of additional interventions available to specific groups of children and their parents, and how parents and the users were reached, for example through publicity, health professionals or the social media. Additionally, indicate if any activities were designed taking into account the social, emotional, cognitive or physical dimensions of child development and, if so, how they achieve this.

3. Please give an account of funding and resources.

Where available, indicate what information is available on costs and funding arrangements. Also indicate what financial resources are available for funding the service and whether food or snacks are provided for the children.

4. Is there information available on service delivery and achievements? If so, please explain what is available.

Include, where possible, an indication of whether the intervention has been evaluated or will be in the future and how progress is monitored. In this context, describe what, if any, data were collected at baseline and what is known about children at entry. Furthermore how do families eligible for the service compare with other families, for example with regard to their social background?

5. What barriers have you encountered when implementing the intervention?

They may be related to funding and bureaucratic restraints or cultural ones, as well as reluctance from institutions, the community or the users.

Thank you very much for your valuable answers and time.

Annex 2. Table with the characteristics of identified interventions provided by the programme managers

Delivery				Description of specific activities			Funding	Evaluation		Barriers
Name and country	Objectives	Target population	Premises	Activities	Dissemination materials	Recruitment / staff	Funding	Coverage/outputs/ outcomes	Baseline	
Programme on food aid and promotion of healthy nutrition, Greece.	To provide food aid and promote healthy nutrition for students in disadvantaged areas.	Students in disadvantaged areas in Greece. For EY specifically, it is carried out in 32 preschools among 1090 children aged 5-7.	Schools.	Daily distribution of healthy lunch bags. Health promotion activities for children and parents.	An activity book, healthy nutrition messages, posters and information material.	Designed and coordinated by Prolepsis Institute in collaboration with volunteers and catering companies.	Funded by the Stavros Niarchos and other foundations. The current school year cost 6.000.000€.	The Program was piloted among 6.300 students. Process evaluation is carried out through problem reporting and focus groups. Impact and outcomes are measured through questionnaires before and after the program. Parents described changes in dietary behaviours. Teachers indicated an increase in school attendance.	65.5% of the families had food insecurity and 29% with hunger among (among 111 schools participating in the project). Data for post project food insecurity as well as dietary behaviours will be available in July.	Continuity of the programme will be reviewed. Problems with questionnaire completion, over reporting and underreporting of food insecurity. Liaising with the owners of the canteens within school premises.
Sure start, Hungary.	To provide caregivers with access to a Children's House.	Families with young children (0-5). Delivered in the 36 most deprived areas in Hungary.	Children's House. Food is provided to children.	Based on UK's Sure Start. Takes into account dimensions of child development.	Health visitors, GPs, social workers as well as local media and posters disseminate the programme.	Inter-sectorial training.	EU Funds.	Planned evaluation was not carried out.	Some assessment at entry on health and social status.	EU project funding lasts 3 years; there is no guarantee for the sustainability of the program.

Mother-baby unit for teenage mothers, Hungary.	To ensure the secure attachment of mothers and their children by providing support to teenage parents.	Teenage mothers (and fathers) (at risk of abandoning their children).	Budapest Child Protection Institute.	The programme does not have a very detailed design.		Professional from a diverse backgrounds with no specific training for running the programme.	Funded by Budapest City Local Authority.	No evaluation, limited follow up. A PhD thesis is planned to assess and evaluate the program.		No strategy or implementation program. Lack of co-operation between the service providers.
Universal health visitation system, Hungary.	Health visits to children and their families.	Expecting mothers and children. Universal coverage.	Home visits.	Provide advice on care of the infants and children, prevention of unwanted pregnancy, recognition of child abuse and maternal depression.		4000 medical health visitors, responsible for 250 children each.	Funding is provided by the central government.	No evaluation, the third party suggests it would be an excellent opportunity for evaluating the quality of care, need assessment etc.		Health visitors lack social training. Insufficient funding, salaries and human resources. Families refuse the health visitors.
Eager and Able to Learn, Northern Ireland.	To improve young children's eagerness and ability to learn through enhancing developmental domains.	454 children aged 2-3.	Home visits and day care settings.	18 Day Care settings and 10 Sure Start settings Support visits and cluster sessions for practitioner	Home-based package for parents which includes workshops, a manual of activities.	A senior early years specialist assigned to each setting.	Approximately £3,500 per setting of 15 children.	Cluster trial using a partial-cross-over design. The programme had significantly positive effects on practitioners' and parents' beliefs, attitudes and (self-reported) behaviours with regard to 2-3 old children's socio-		Needs to engage more parents in the process, to consider the logistics of home visits and ensure the better preparation of practitioners for these visits. Additional funding.

				s Workshops for parents of children who participated in the programme.				emotional development.		
Toy box, Northern Ireland.	Rights based outreach play services to Traveller families with children aged 0-4 years to enhance children's developmental domains.	Traveller families.	Home visits.	Weekly home visits by project workers. Issues which can negatively impact on development and progression are addressed.	DVD "My Child" which captured the learning of both children and parents engaged in the project Book: "Tales of the Road".		It receives £350,000 each year for salaries, running costs and resources.	In 2006 an evaluation was completed with positive results. Monthly statistical information of uptake of service and compared with annual targets. Qualitative information is provided.	35.3% (children?) have difficulty in reading and filling out forms. ¼ of the families consider where they live to be unhealthy. Breastfeeding for children is 7.1%.	Families are reluctant to staff visits. Unregistered and hard to access families. Back lash from the closure of local Traveller Support Groups.
Maternal Centre Iris, Romania .	To provide shelter for mothers and children during 6 months.	Single mothers aged 14-25. 60% are Roma and the majority are unemployed.		Encouraging to bond with their babies. Child-care and other skills as well as self-restraint.		The head of the centre is a trained social worker.	The directorate of social assistance and child protection.	No evaluation or follow up. Some accounts of positive perceptions on mothers' behalf.		
Theotokos centre,	To offer child-care support to	Mothers who lack social and or financial	Children's centre.	Day care services. Three			The Christian Orthodox Mission	Psychologist and speech therapist evaluate the		Limited space and resources the centre can only

Romania .	single mothers and families in difficult situation	support.		meals. Counselling Health care and information services for parents. Financial and social services support for mothers.			Centre, USA, the Orthodox Archbishop's Office, Cluj and grants from the county council.	children's development.		accept 30% of applicants.
Mother's club, Romania .	To improve quality of life of parents and their children.	Professional mothers from minority Hungarian-speaking groups.	Rented premises.	Pre-natal exercises ... Musical activities and active playing, taking into account developmental goals.	Recruitment through Facebook, e-mail and newspapers.	Trained therapist and volunteers.	Members support their own activities with their own voluntary contribution.	No formal evaluation of achievements.		Absence of paid personnel.
Netzwerk Familie	The programme aims to promote positive child development by identifying and supporting families in need of assistance when children are	Families in need of children 0-3.	Home visiting telephone contacts or accompanying families to other services.	The interventions available cover many different areas: activities to ensure a stable income and housing,	6 social workers working 168 hours weekly Accompanying approximately 150 families. In addition, 2 persons (30 hours weekly) take care of	The programme is funded by the province of Vorarlberg (regional government) – the case management as well as the network management of the Family Network. In	The programme is reaching about 4 % of all children born in the province. An evaluation of the start-up process a few years ago was already carried out. An annual report provides an overview on the families entering the programme as well as the interventions	Families are from socially disadvantaged background.	Competition - some services become worried that because of this new programme they might lose clients resp. funding. Since it turned out not to be case – but instead clients have been referred to them by the new	

	0-3.			home visiting activities, interventions to promote parenting skills, therapeutic intervention and family support.		network management, public relations, monitoring.	addition, the interventions and services available within the network are also funded by the regional government and free of cost for the families.	provided and the duration in the programme. There are plans to carry out an in-depth evaluation for some time and it seems that such an evaluation might start soon.		programme – it become less of a barrier.
--	------	--	--	---	--	---	---	--	--	--

Annex 3. Quantitative description of the delivery of the intervention or service

- Socioeconomic context of the intervention and any information on the local area considered relevant
- Socioeconomic data on intervention users and their families
- Objectives
- Target population
- Premises
- Description of specific activities and whether they take the different dimensions of child development into account
- Dissemination materials and resources
- Recruitment strategies and identification of potential users
- Funding, resources and costs
- Evaluation
 - Coverage/reach of the intervention
 - Outputs evaluated
 - Outcomes evaluated
 - Baseline information collected
- Barriers and enablers to implementation

Annex 4. Proposed interview guide

- Could you please describe the socioeconomic context of the area and users receiving the service?
- Which service is being delivered? Please describe it and its objectives.
- Why was this intervention selected to address potential inequalities in early child development?
- Has this service been implemented in other countries or cities?
- Please explain the impact of the intervention on reducing inequalities in health and early childhood development.
- Who are the intended users or beneficiaries of the intervention?
- Does the intervention reach the intended beneficiaries or population groups who would benefit from it more?
- In which premises is the intervention or service delivered?
- Which are the specific activities related to the service or intervention?
- How do these take into account the different dimensions of child development?
- How are users identified?
- What funding and resources does the service receive?
- Has the service undergone an evaluation?
- Do you know of any barriers encountered when implementing the intervention or service?



DRIVERS (2012-2015) is a research project funded by the EU's 7th Framework Programme. It aims to deepen understanding of the relationships between some of the key influences on health over the course of a person's life - early childhood, employment, and income and social protection - and to find solutions to improve health and reduce health inequalities.

The research is undertaken by a consortium including leading research centres and organisations representing the public health sector, civil society and businesses.