

Inventory and Analysis of Promising and Evidence-based Parent- and Family-Focused Support Programs

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EXECUTIVE SUMMARY

Child development takes place in different contexts, such as the family and non-familial care arrangements. The characteristics of the environment in which child development takes place are important for child development. At the same time the child shapes his or her environment. The family is the first and most relevant microsystem for children in their early life. Many studies have provided evidence and discussed the impact of the family on child development (Adi-Japha & Klein 2009, Bornstein & Bradley, 2008, Gottfried, Fleming, & Gottfried 1998, Hart & Risley, 1995; Melhuish et al., 2008, NICHD Early Child Care Research Network 2003a; 2003b; Sylva et al. 2004). Children growing up in poor families, in families with low socio-economic status or children from immigrant families show disadvantages in their cognitive, language and socio-emotional development as early as at the age of 3 years or even younger (George, Hansen, & Schoon, 2007). As a consequence, many countries have set up different approaches to support families and to promote the quality of the home learning environment. At the level of centre-based ECEC, efforts have been undertaken to (1) provide early access to preschool education and to rise attendance rates, especially for children of disadvantaged families, and (2) to strengthen preschool-parent partnership as an area of work and as an important quality dimension of preschool education and the following levels of the education system. Furthermore, various home- and community-based approaches have been developed. The effectiveness of many approaches still needs to be evaluated in different contexts, including its connections to other services. Existing program evaluations often tend to not consider minority parents' views and needs appropriately. Views and beliefs of different target groups as an important component of the quality of the home environment they provide is often not sufficiently considered in present program developments and research. The views and impact of further stakeholders seem to be often neglected. In addition, only a minority of approaches consider the home language of parents appropriately. A further important research question is associated with the potential of implementing and using ICT, particularly for immigrant parents and parents with low socioeconomic status.

The inventory and analysis of promising and evidence-based parent- and family focused support services/programmes provides social context indicators on family support and educational inequalities for the Czech Republic, England, Germany, Netherlands, Norway, Poland and Portugal. Country profiles of these countries describe child and family services, and how country policies deal with equality issues, monitoring, and language support. In addition, a selection of evidence-based and promising family support services/programmes is provided. This set of programmes is analysed with regard to existing challenges and their potential to overcome them.

Social context indicators on family support & educational inequalities

The percentage of people born in a country other than the country of residence varies considerably across participating countries, ranging from 1.65% in Poland to 14.85% in Norway. But regarding the proportion of children under the age of 5, the countries do not differ markedly from one another. Income inequality varies considerably across the countries. Norway, Czech Republic, and Netherlands have the lowest inequality levels of disposable income while inequality is particularly high in Portugal. Along with variation in income inequalities, the countries differ in rates of child poverty or social exclusion. Of the seven countries, the UK has the highest rate of young children who are at risk of poverty and social exclusion (31.6%).

Portugal, and to a less extent, Poland, also have relatively high child poverty rates of 24.8% and 22.8%, respectively. Family friendly social policies also include leave policies that enable parents to take care of their very young children at home (Adema et al., 2015). The participating countries vary considerably in terms of priorities and approaches to parental leave (Eurydice & Eurostat, 2014). ECEC provision seems an important means to reduce social inequalities (Eurydice, 2014). Participation rates for children aged between 3 and 5 are relatively high in all countries. Rates for children under 3 tend to be lower, and differ considerably more across countries. In Norway, Portugal and Netherlands around one-in-two children under 3 participate in ECEC, while in the Czech Republic and Poland, less than one-in-twenty children under 3 participate in ECEC.

Parenting and family support services across seven countries

Although in all countries family support encompasses a broad range of services that cross several sectors, there are important variations across countries. The main cross-country differences are related to both the main approach taken to the support of parenting and the extent to which parenting support is integrated in a clear policy framework. In England, Germany, Netherlands, and Norway, parenting support has been incorporated into national comprehensive early intervention strategies. In these countries, parenting support is part of a clear strategic framework that integrates a broad range of early intervention and prevention services for families. These countries also share a trend towards more integrated approaches to child and family services at the local level, through local networks, local structures and coordinated support centres. At the same time, in these countries, there has been a trend towards more holistic approaches to young people and their parents (Boddy et al., 2009), with an emphasis on early preventive intervention and greater state engagement with parents (Daly, 2013). Following a strong preventive orientation, services appear to favour a continuum of care, incorporating parenting support in a range of services and actions that provide parents with resources and support mechanism. In most countries, other sectors (than social/welfare, which are mainly in contact with vulnerable families) have been involved (health and education), highlighting the preventive focus of support.

Analysis yielded a great variety of underlying theoretical frameworks for selected evidence-based and promising practices of services and programmes for parenting and family support and education. In addition to services/programmes that do not have a defined theoretical framework or are anchored in “broadly defined” parenting theories, one can find a wide array of informing theories, with contrasting levels of specificity. One interesting pattern to highlight is the international coverage of some programmes and their inclusion either in the general country services/programmes, or at a local level. In effect, there are several examples of parental support programmes that have its origin in one country and that are adapted and implemented in another country. This is most evident in the Netherlands, Germany, and, to a lesser extent, Norway and England. The transnational use of several programmes is a good indicator that countries are communicating and learning from each other’s experiences. Nevertheless, it is important to stress a word of caution, related to the need to study the efficacy of a programme in every particular new context, even if there is good empirical evidence of that same programme’s efficacy in another context. Consideration of pre-existent services, in addition to local needs and specificities, along with careful implementation plans and continuous monitoring are needed to ensure quality implementation. All approaches and programmes have

shown positive effects or include elements that have shown to be effective in other contexts. Although there are a number of existing services or programmes aiming at diminishing children's educational gaps through parental/family support and education, which have been evaluated through high standard quality studies, little is known about the differential effectiveness of these same services or programmes between disadvantaged and disenfranchised groups (notably the ISOTIS target groups) and the overall population.

Several programmes aim at increasing outreach and use active recruitment strategies to increase outreach. Several strategies were identified: guaranteed translation for services, inclusion among the staff of members of the minority that the service or programme is trying to reach, universal money incentives, and dedicated teams to small but very highly disenfranchised groups. Possible tensions were identified between strategies to improve outreach that resort to members of minority groups (namely as staff) and the maintenance of the quality of the delivered service or programme. This structural challenge may be overcome by tailoring the planning and resources of interventions, and perspectives may be seen in using second-generation well-educated migrants as staff. In addition, further means to guarantee the implementation quality such as regular monitoring and professional development throughout the process may be incorporated.

The vast majority of the included programmes – although considered evidence-based or promising practice – related to the ISOTIS target groups, do not deliberately target multicultural goals. Multicultural goals, however, according to current evidence reviewed in this report, would be essential in order to downplay intercultural conflict and stereotype threat. Research evidence has been provided that proficiency in the first language is not only relevant for the development of language and communication skills of the children, but also and even more important for developing a multicultural identity without losing the link to their cultural origin. Prior research has shown that many immigrant parents in different countries and contexts articulate the wish for more respect for their home languages and better implementation of different languages within the educational systems.

The analysis of the system contexts and the overview of evidence-based and promising practices has led to recommendations for potentially effective interventions. These relate to different characteristics of the programme design, programme implementation and research.

1. INTRODUCTION

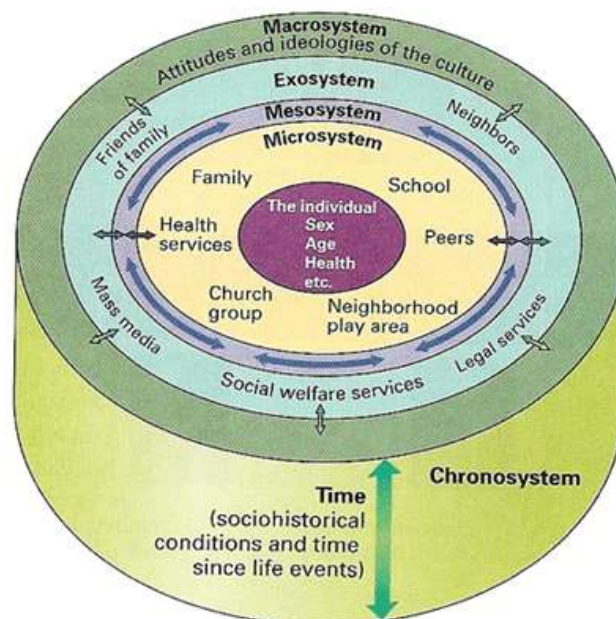
Empirical studies from different countries have documented that children differ in their competencies and skills already at preschool age (Magnuson, Meyers, Ruhm & Waldfogel, 2004; NICHD ECCRN, 2002, 2005). Children growing up in poor families, in families with low socio-economic status or children from immigrant families show disadvantages in their cognitive, language and socio-emotional development as early as at the age of 3 years or even younger (George, Hansen, Schoon, 2007). Analysing the educational careers of these children, it becomes obvious that these disadvantages are often maintained or grow bigger over the life span (Anders, Grosse, Roßbach, Ebert & Weinert, 2013; Leseman, Mulder, Verhagen, Broekhuizen, Slot, & Van Schaik, 2017; Sammons et al., 2008; Weinert, Ebert & Dubowy, 2010). Longitudinal studies on potential benefits of preschool programmes have shown that high quality preschool education may be an effective means to foster children's development and to compensate for early disadvantages (Melhuish et al., 2015). At the same time, research showed that family influences on children's development are always stronger than any institutional educational influence. Preschool programmes with moderate to strong effects could be characterized as those programmes considering the influence of and working with parents and families than just working with children. Famous examples are the well-known US-American intervention studies, such as the Perry-Preschool programme (Schweinhart, Barnes, & Weikart, 1993; Schweinhart, Montie, Xiang, Barnett & Belfield, 2005) or the Abecedarian programme (Campbell, Ramey, Pungello, Sparling & Miller-Johnson, 2002). A consistent finding is that, the earlier programmes start the higher the expected compensatory effect for cognitive outcomes (Halpern 2000).

These findings are in line with theoretical models of child and human development such as the Social Ecological Framework of Uri Bronfenbrenner (1981, 1986). According to this model child development takes place in different contexts such as the family or non-familial care arrangements. The characteristics of the environment in which child development takes place are important for child development. At the same time the child shapes his or her environment. Bronfenbrenner postulated that the entire ecological system in which growth occurs needs to be taken into account to understand human development. Processes, personal resources, contexts and time need to be considered in their interplay.

As contexts, he distinguished several subsystems that guide and influence human development. The micro-system contains the structures directly affecting the child, encompassing the relationships and interactions a child has with his or her immediate surroundings (e.g., family, preschool, school). The mesosystem describes the connections between microsystems (e.g., family and preschool) and thus provides the structural link between microsystems. Further systems are the exosystem, defining the broader social system. The child is not a member of the exosystem, but the exosystem has an influence on one or more microsystems and influences the child indirectly. The workplace of a parent is one example of an exosystem. The macrosystem comprises societal institutions, cultural norms, societal values and shared belief systems of societal groups. It also represents aspects such as the social structure of a society, demographic developments and how social inequalities are addressed in a society. All these values and conditions affect or are transferred into values and processes of the exo-, meso- and microsystems of a child. Strategies and programs to influence parental skills and to enhance parent involvement are also linked to the mesosystem. Partnerships between pre-school settings and families is one important example in this context.

The systems are changing over the life course of the child. Systems are subject to change and new systems occur for example when transitions between educational institutions happen (e.g., primary school enrolment) or when the child enters new systems (e.g., a new peer-group). The model does not endorse a simple transmission view of development and education. Thus, not only system influences of child development are assumed, but at the same time the child is seen as an active creator of its environment and therefore shaping the systems according to its interests and needs. The chronosystem takes this understanding up. It includes major life transitions, environmental events and historical events that occur during development. The specific incidents tend to change how the child interacts with all the rest. Moving to another city is one example, the refugee crisis another. Figure 1 illustrates the overall model.

Figure 1. The bio-ecological model of Uri Bronfenbrenner



While many studies have provided evidence and discussed the impact of the family on child development (Adi-Japha & Klein 2009, Bornstein & Bradley, 2008, Gottfried, Fleming, and Gottfried 1998, Hart & Risley, 1995; Melhuish et al., 2008, NICHD Early Child Care Research Network 2003a; 2003b, ; Sylva et al. 2004), only few scientists have provided sound and comprehensive theoretical models to describe the structure and modes of action of the home environment. Kluczniok and colleagues (2013) provide a synthesis of different theoretical assumptions. The quality of the home environment is understood as a multidimensional concept, capturing the dimensions of structural quality, process quality and parental beliefs. Structural quality refers to aspects such as family income, parental educational level, socioeconomic status and immigration status, but also the availability of materials and other environmental characteristics (e.g., size of the house). Parental beliefs cover educational beliefs such as educational aspirations and values and process quality refers to the activities (e.g., book-reading, outdoor activities, going to the library) and the quality of interactions between parents and children as well as the family climate as a whole. The model assumes that structural aspects and beliefs have an impact on process quality which in turn directly affects

children and their development. This model has important implications: It differs clearly between structural aspects of the home environment and the quality of interactions. This important difference is in line with research showing that the quality of pedagogical interactions in the family is often linked to, but not pre-determined by, background characteristics such as low socioeconomic status or low educational level of the parents. It also highlights the relevance of parental beliefs which may be a key for effective interventions (e.g., beliefs regarding the appropriate age of enrolling children to preschool or self-efficacy beliefs). For example, Fan and Chen (2001) showed that parental expectations and aspirations are strong predictors of children's school success. Immigrant parents' beliefs in child-rearing and their educational aspirations may be different from non-immigrant parents due to cultural reasons. Anders, Hachfeld and Wilke (2015) recently provided evidence in a German intervention study that immigrant parents' perceived self-efficacy with regard to the education of their preschool aged child is lower than that of German parents. Parents' beliefs explained the link between immigration status and educational activities.

Various initiatives in many countries have been developed over the last years to overcome early disadvantage by taking an effect on family environments. Different societal levels have been subjected to change and intervention. At the level of centre-based ECEC, efforts have been undertaken to (1) provide early access to preschool education and to rise attendance rates, especially for children of disadvantaged families, and (2) to strengthen preschool-parent partnerships as an area of work and as an important quality dimension of preschool education and the following levels of the education system. Furthermore various home- and community-based approaches have been developed in many countries. These approaches try to operate as low-threshold provision, taking up families and their individualized specific needs in their local environments.

Family-systems intervention models include a set of both conceptual and operational principles that structure approaches to working with families. One of them is the 'resource-based approach' to early intervention which grew out of the work of Dunst and his colleagues (e.g., Dunst & Trivette, 2009). The fundamental assumption of the resource-based model, based on Bronfenbrenner, is that families and children are embedded within a number of ecological systems, and that child development and family functioning can be supported by assets and strengths within those systems. The resource-based model has three components: sources of support (personal social network members, associations community programs and professionals, specialized services), community resource mapping (identifying and locating the different resources that exist in a given area), and building community capacity (identifying strengths and assets of a community and eliminating barriers through use of other resources) (Trivette, Dunst & Deal, 1997). Principles are highly grounded in kinds of enabling experiences and opportunities that will empower families and strengthen parenting and family functioning (Dunst & Trivette, 2009; Forry et al., 2012). These models take a strengths-based and resource-based approach, recognize the family and not just the child as the intervention unit, and are guided by a promotion model of optimization of competence and positive functioning, rather than a treatment model.

Methodologically sound studies on the effectiveness of different approaches to working with families are still rare. With regard to the potential benefits of close and high-quality partnerships between preschools and parents, longitudinal evaluations of the early US-American intervention studies (e.g. Bulotsky-Shearer, Wen, Faria, Hahs-Vaughn, & Korfmacher,

2012; Dearing, Kreider, Simpkins, & Weiss, 2006; Fantuzzo, McWayne, Perry, & Childs, 2004; Hindman & Morrison, 2011; Webster-Stratton, Reid, & Hammond, 2001) provide affirmative evidence, but also recent European studies point to beneficial effects (Anders et al., 2015; Homem, Gaspar, Seabra-Santos, Azevedo, & Canavarro 2014, Evangelou, Brooks, & Smith (2007). Regarding home- and community-based approaches, many of them have not been evaluated. Existing studies point to potential benefits of various programmes, but also point to existing challenges. Until now it remains unclear which characteristics of the programmes determine their failure or success. One aspect may be the delivery mode. Blok et al. (2005) conducted a meta-analysis and found that centre-based programmes or programmes that combined home-based and centre-based approaches were more effective than home-based programmes in the cognitive domain. Furthermore, positive effects were found for programmes that included the coaching of parenting skills. Research and practice experiences also point to major challenges. Different programmes may be differentially effective for target groups in different cultural environments. Many programmes seem to be well conceptualized, but still suffer from a lack of outreach to the target group or a lack of connection to other local services provided to parents. The effectiveness of many approaches still needs to be evaluated, including its connections to other services. Existing programme evaluations often tend to not consider minority parents' views and needs appropriately. Views and beliefs of different target groups as an important component of the quality of the home environment they provide is often not sufficiently considered in present programme development and research. The views and impact of further stakeholders seem to be often neglected. In addition, only a few approaches consider the home language of parents (De Angelis, 2015; Genesee, Lindholm-Leary, Saunders, & Christian, 2005; Hancock, 2002; Iluz-Cohen & Armon-Lotem, 2013; Roberts, 2008). A further important research question is associated with the potential of implementing and using ICT, particularly for immigrant parents and parents with low socioeconomic status. Although reviews and meta-analyses exist, they are often based on North-European and US-American programmes and research. But contextual factors and challenges vary greatly between countries, so the consideration of other countries is highly needed.

Based on this state of research and practice, the inventory and analysis of promising and evidence-based parent- and family focused support programmes provides social context indicators on family support & educational inequalities for the Czech Republic, England Germany, Netherlands, Norway, Poland and Portugal. This analysis is followed by country profiles of these countries describing family and child health services and how country policies deal with equality issues, monitoring, and language support. The main challenges with regard to the ISOTIS aims and target groups in these countries are highlighted. In the next part a selection of good and promising family support programmes based expert evaluations is provided, and the set of programmes is analysed with regard to existing challenges and their potential to overcome them. In the discussion, existing dilemmas and possible solutions are taken up, and research questions for the next step of WP 3 ISOTIS research are explored.

2. THE CONTEXT FOR PARENTING & FAMILY SUPPORT THROUGH AN EQUITY LENS

Joana Cadima & Gil Nata

The first two sections of the report present an up-to-date overview of the practical context in which parenting programs and services are created and implemented. The main aim is to provide an overall description that helps to understand the national contexts of policies and services that support parents and families, framed by an equity perspective. To achieve this aim, it seems useful to focus a) on particular social indicators and b) an overview of the available family and parenting support services for ISOTIS target groups (immigrant background/non-native speakers; Roma/ethnic minorities; Low-income/general social risk) in each country.

2.1. THE CONTEXT OF PARENTING SUPPORT: SOCIAL CONTEXT INDICATORS

Parenting support is embedded into a social context within the countries which has high impact on the country-specific challenges and approaches. Using OECD and Eurostat data, this chapter provides key information on family policy issues for the seven countries through the presentation of a set of social context indicators relevant for understanding the social landscape of the participating countries. It provides comparable data on policy-focused measures of family support and contextual factors likely to influence these policies. Five major topics are covered:

- . Population
- . Income inequalities
- . Child poverty
- . Parental leave policies
- . Early childhood education and care (ECEC)

2.1.1 POPULATION

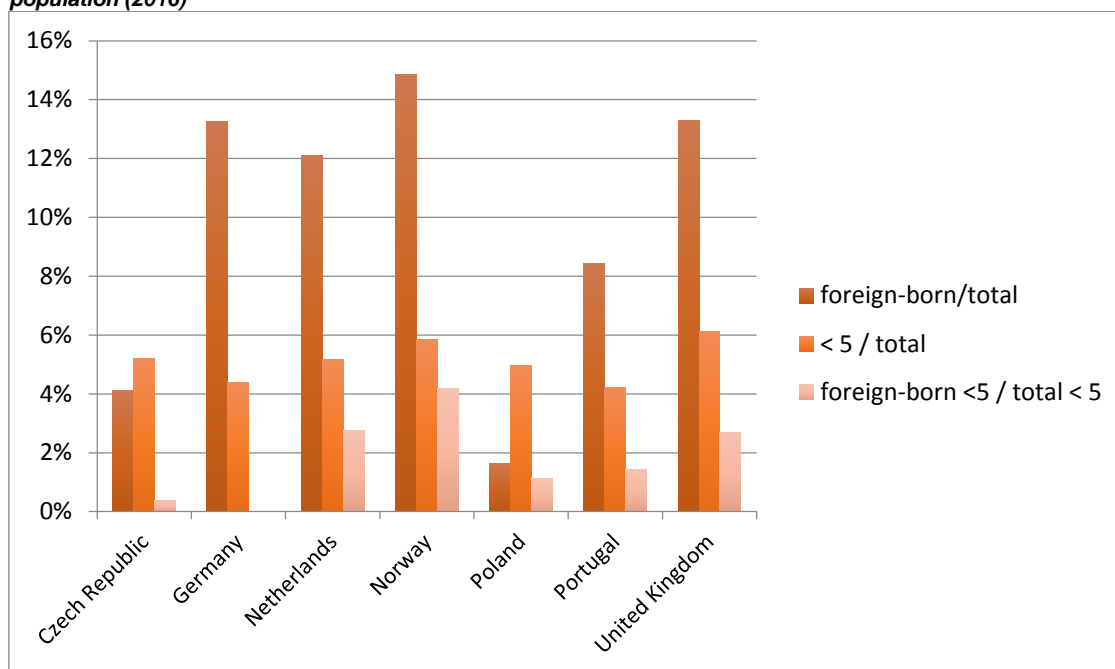
Contextual factors, namely the proportion of immigrants and proportion of young children in a given country, are likely to influence social and family-related policies of the countries. Figure 2.1.1 shows indicators of the population, specifically the proportion of people with a different country of birth¹, the proportion of children aged less than 5 years, and the proportion of children with a different country of birth. Even though it is taken for granted that societies are becoming more culturally and linguistically diverse, there are important differences across the participating countries.

The percentage of people born in a country other than the country of residence varies considerably across participating countries, ranging from 1.65% in Poland to 14.85% in Norway. Regarding the proportion of children under the age of 5, the countries do not differ markedly from one another, with rates ranging from 4.22% in Portugal to 6.14% in the United Kingdom (UK). In all countries, children under the age of 5 with a different country of birth represent a small proportion (less than 5%) of the population aged under 5, although there are some

¹ Eurostat definition of country of birth: the country where a person was born, that is, the country of usual residence of mother at the time of the birth. Native-born - Person born in the country of residence (country of survey/enumeration). Foreign-born - Person born in other country than country of residence (Eurostat, 2007).

variations across countries. Czech Republic has less than 0.5% of children with a different country of birth over the under 5 population, whereas Norway has more than 4%. . However this does not necessarily reflect the cultural diversity within a country as, young children may be born by second or third-generation immigrants.

Figure 2.1.1. Percentage of foreign-born population and children under the age of 5 relative to the total population (2016)



Source: Our calculations over the following Eurostat category: "Population on 1 January by age group, sex and country of birth [migr_pop3ctb]". Data for Germany for children (<5) by country of birth is not available. These indicators were built from our calculations over Eurostat data (for the year 2016). The first column (foreigners/total) is the total number of respondents with a different country of birth than the one indicated divided by the total number of the country's population (and multiplied by 100). The second column (< 5 / total) is the total number of under 5 population divided by the total number of the country's population (and multiplied by 100). The third column is the total number of under 5 population with a different country of birth than the one indicated divided by the total number of under 5 population (and multiplied by 100). Data from the year 2016 (latest available for the 7 countries).

2.1.2 INCOME INEQUALITIES

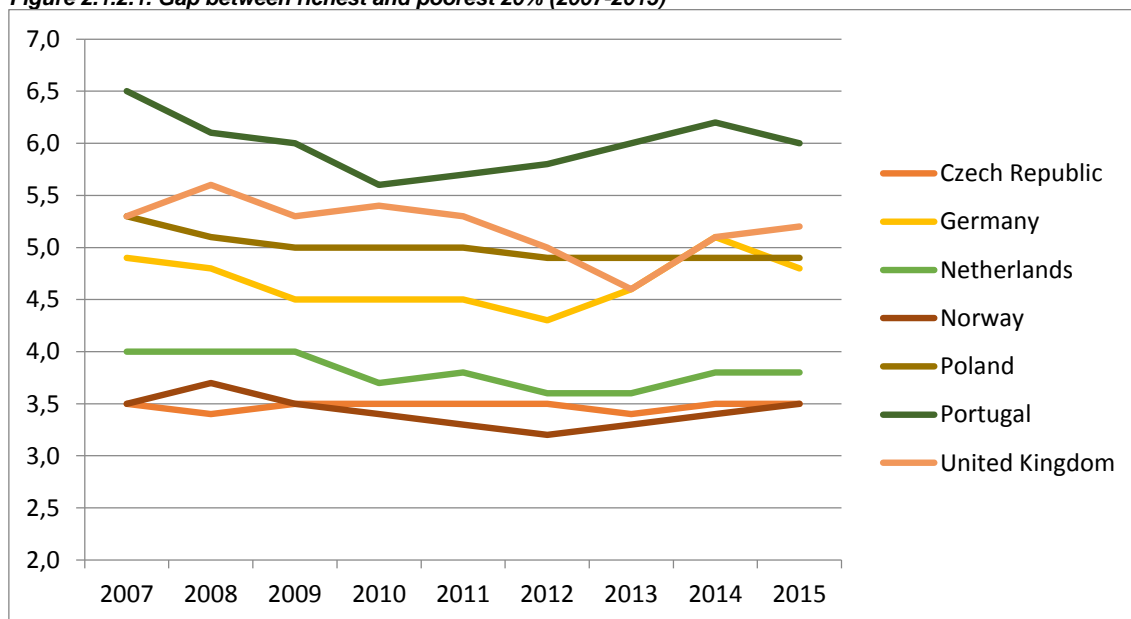
Figure 2.1.2.1 shows inequality trends between the average income² of the 20% richest and the 20% poorest of the population over the period 2007–2015 in participating countries. Income inequality varies considerably across the countries. Norway, Czech Republic, and the Netherlands have the lowest inequality levels of disposable income while inequality is particularly high in Portugal. The gap between the average income of the richest and the poorest 20% of the population in 2015 was 6 to 1 in Portugal, whereas in Norway and Czech Republic it was 3.5 to 1.

Between 2007 and 2015, the income gap between 20% richest and the 20% poorest remained broadly stable in most participating countries, although there was some variation in UK and Germany and, to a lesser extent, in Portugal. The income gap fell most in UK between 2011 and 2013, although it has recently increased. Germany and Portugal also showed an increase on income inequalities, with a sharp increase in Germany, between 2012 and 2014,

² Eurostat definition: Equivalised disposable income is the total income after tax and other deductions, adjusted by the size and composition of households.

and a continuing increase in Portugal, between 2010 and 2014. However, both Portugal and Germany show a new decrease between 2014 and 2015.

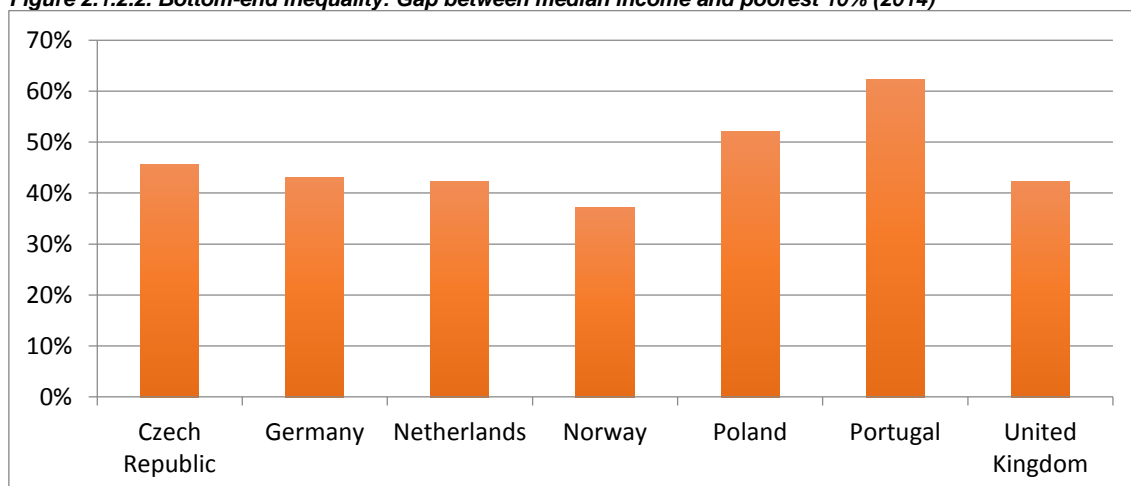
Figure 2.1.2.1. Gap between richest and poorest 20% (2007-2015)



Source: EU-SILC survey [ilc_di11]. Eurostat data on inequality of income distribution (income quintile share ratio). Last update 14.09.17. Extracted on 15.09.17. The income quintile share ratio or the S80/S20 ratio is a measure of the inequality of income distribution. It is calculated as the ratio of total income received by the 20 % of the population with the highest income (the top quintile) to that received by the 20 % of the population with the lowest income (the bottom quintile). All incomes are compiled as equalised disposable incomes.

Complementary income inequalities indicators have focused on the poorest children and the extent to which the poorest 10 per cent fall further behind the median income (Innocenti, 2014). Portugal stands out in having a particular severe income gap, where the poorest 10 per cent of children are in a substantially worse position compared to the other children (Figure 2.1.2.2).

Figure 2.1.2.2. Bottom-end inequality: Gap between median income and poorest 10% (2014)



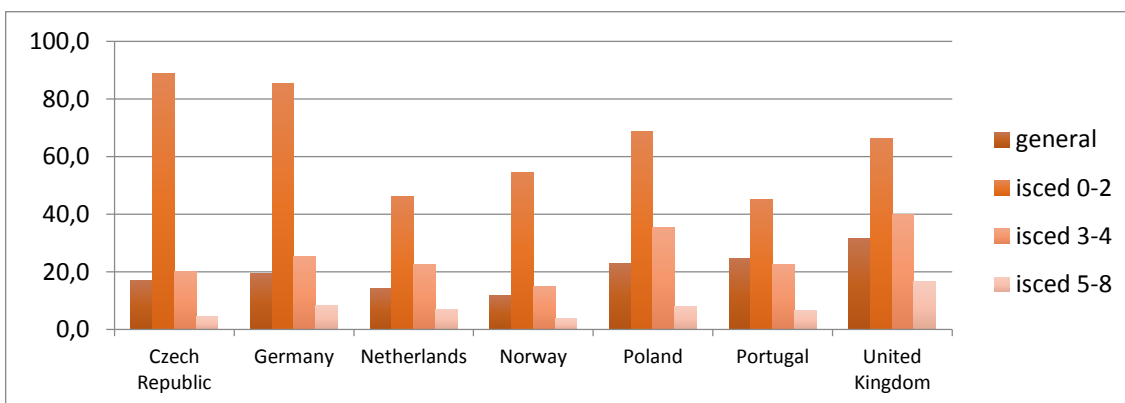
Source: Innocenti Report Card 14. Relative income gap between median income and that of the bottom 10 per cent of households with children, 2014. Relative income gap ('bottom-end inequality') is measured as the gap between household income of a child at the 50th percentile (the median) and that of a child at the 10th percentile, reported as a percentage of the median.

2.1.3 CHILD POVERTY

Along with variation in income inequalities, the countries differ in rates of child poverty or social exclusion³. Of the seven countries, the UK has the highest rate of young children who are at risk of poverty and social exclusion (31.6%; Figure 2.1.3.1). Portugal, and to a less extent, Poland, also have relatively high child poverty rates of 24.8% and 22.8% respectively.

Inequalities in child poverty. In all countries, a key factor that influences the likelihood of child poverty is parents' level of education. Overall, the poverty rate is not evenly spread across all groups of children (Figure 2.1.3.1). However, and although children in all countries face a higher risk of poverty and social exclusion when their parents are low educated, in Czech Republic and Germany this percentage is very high, with more than 85% of children from low-educated families being at risk of poverty. Parents' country of birth also affects the likelihood of child poverty⁴ in nearly all countries (Figure 2.1.3.2). With the exception of Poland and, to less extent, Portugal, children with at least one parent who was born abroad face a higher risk of poverty. In Czech Republic, UK and Norway, the children of foreign-born parents have income poverty rates that are at least 10 percentage points higher than those of children with native-born parents. Reversely, in Poland, the poverty rates of children with foreign-born parents are lower than those of children born in the country. International data also shows that countries differ in their effectiveness in reducing child poverty rates through social transfers⁵ (Figure 2.1.3.3). While on average, countries such as Norway, UK, Germany, the Netherlands and Czech Republic reduce the poverty rates by almost a half, Poland and Portugal are less effective, reducing the poverty rate by approximately only a quarter.

Figure 2.1.3.1 Children under 6 at risk of poverty or social exclusion by parents' level of education (2015)



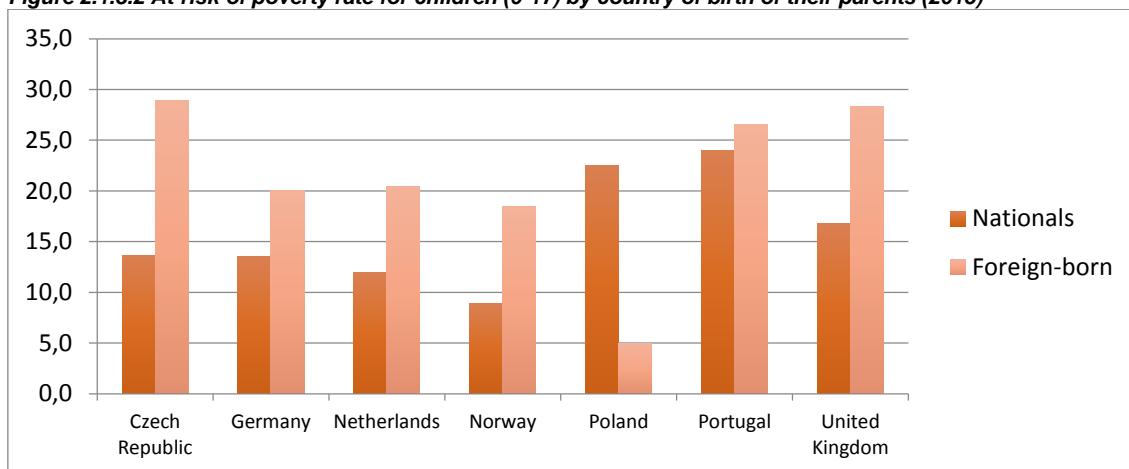
Source: Eurostat. First column is the percentage of children below 6 years old that are at risk of poverty or social exclusion. Second to fourth columns represent the percentage of children below 6 years old that are at risk of poverty or social exclusion by parents' level of education (ISCED 11): ISCED 0-2: Less than primary, primary and lower secondary education; ISCED 3-4: Upper secondary and post-secondary non-tertiary education; ISCED 5-8: Tertiary education. Data from the year 2015 (latest available for the 7 countries).

³ Eurostat definition: At risk of poverty or social exclusion refers to the situation of people either at risk of poverty, or severely materially deprived or living in a household with a very low work intensity. Severe material deprivation refers to the percentage of the population that cannot afford at least four of the following nine items (to pay their rent, mortgage or utility bills; to keep their home adequately warm; to face unexpected expenses; to eat meat or proteins regularly; to go on holiday; a television set; a washing machine; a car; a telephone). The indicator persons living in households with very low work intensity is defined as the number of persons living in a household where the members of working age, with the exclusion of students, worked less than 20 % of their total potential during the previous year.

⁴ Eurostat definition: The at-risk-of poverty rate is measured as the share of persons with an equivalised disposable income below the at-risk-of-poverty threshold. Threshold is 60% of the national median equivalised disposable income.

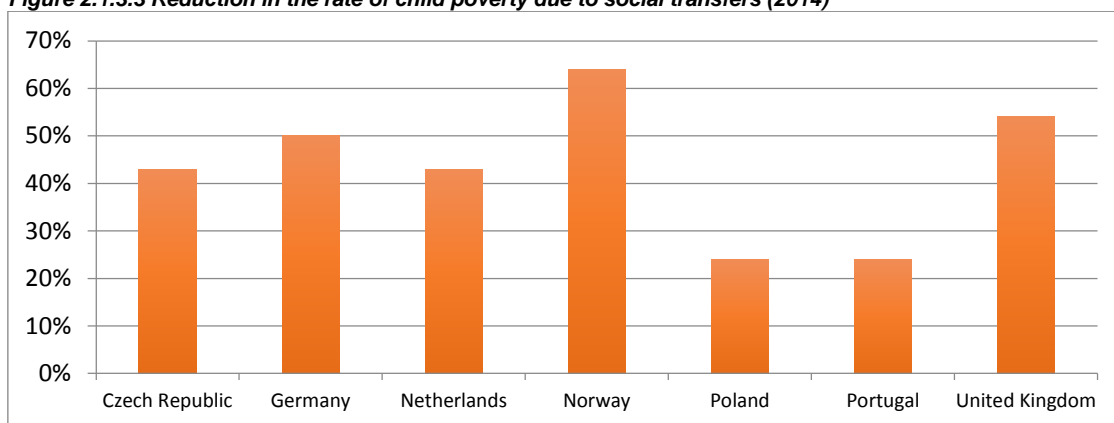
⁵ Innocenti card: Reduction in child poverty is measured as the proportional difference between child poverty rates before and after social transfers. Child poverty rates are measured using income thresholds at 60 per cent of the median household income of the total population, before and after social transfers.

Figure 2.1.3.2 At-risk-of poverty rate for children (0-17) by country of birth of their parents (2015)



Source: Eurostat. At-risk-of poverty rate for children (population aged 0 to 17 years) by parents' country of birth (two categories: Country of birth = "Reporting country"; Country of birth = "Foreign country"). Data from the year 2015 (latest available for the 7 countries).

Figure 2.1.3.3 Reduction in the rate of child poverty due to social transfers (2014)



Source: Innocenti Report Card 14. Percentage reduction in the rate of child poverty due to social transfers, 2014.

2.1.4 PARENTAL LEAVES

Family friendly social policies also include leave policies that enable parents to take care of their very young children at home (Adema et al., 2015). The participating countries vary considerably in terms of priorities and approaches to parental leave (Eurydice & Eurostat, 2014).

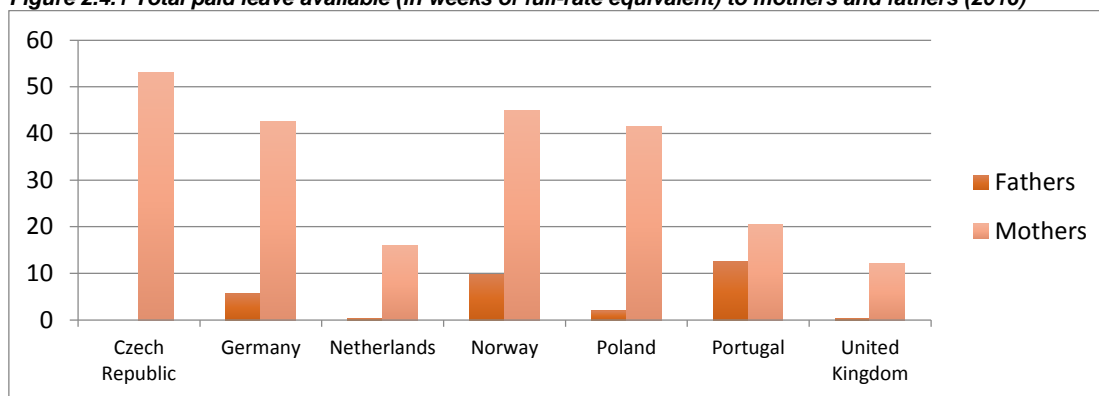
Figure 2.1.4.1 shows paid leave entitlements⁶ in participating countries in 2016. There are cross-country differences in the length of parental leaves (adjusting for the payment rates). Czech Republic, Norway, Germany and Poland provide more than 40 weeks of parental leave, which contrasts with the Netherlands and United Kingdom, that provide far shorter parental leaves (less than 17 weeks). All countries, with the exception of Czech Republic, have introduced father-specific paid leave periods, even though the father-specific entitlements tend to be shorter compared to parental leaves⁷.

⁶ OECD's Family Database: Paid leave entitlements include paid maternity, paid parental leave and subsequent periods of paid home care leave to care for young children. It is an estimate of the length of the leave (in weeks) with full-rate payment, adjusting the length of the leave in weeks by the average payment rate. The average payment rate refers the proportion of previous earnings replaced by the benefit over the length of the paid leave entitlement for a person earning 100% of average national (2015) earnings. When there is more than one period of leave at two different payment rates, a weighted average is calculated based on the length of each period.

⁷ It is important to mention that in several countries fathers as well as mothers can take parental leave and it is upon the

Public expenditure⁸ on parental leave schemes also varies across countries and follows a similar pattern of the leave entitlements (Figure 2.1.4.2). Norway and, to a lesser extent, Czech Republic, direct larger proportions of their public expenditure towards maternity and parental leaves, compared to the other countries. In contrast, the Netherlands directs a small proportion of the public expenditure towards maternity and parental leaves.

Figure 2.4.1 Total paid leave available (in weeks of full-rate equivalent) to mothers and fathers (2016)



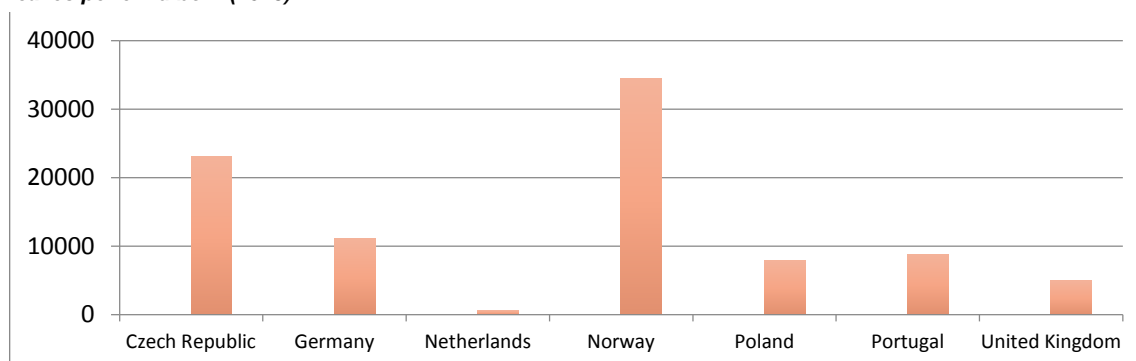
Source: OECD's Family Database.

Fathers: Summary of paid leave entitlements for fathers; Paid paternity leave and paid parental and home care leave reserved (or effectively reserved) for fathers, in weeks (2016).

Mothers: Summary of paid leave entitlements available to mothers; Paid maternity, parental and home care leave available to mothers, in weeks, (2016).

Source: OECD's Family Database (OECD Social Expenditure Database; OECD Health Statistics). Data for Chart

Figure 2.4.2. Public expenditure (at current prices and current PPPs, in US dollars) on maternity and parental leaves per child born (2013)



PF2.1.D. Public expenditure on maternity and parental leaves, 2013. Public expenditure on maternity and parental leaves per child born, at current prices and current PPPs, in US dollars. Data for Poland refer to 2012.

decision of the parents who is going to take the leave. By father-specific paid leave periods, OECD refers to "entitlements to paternity leave or periods of parental leave that can be used only by the father and cannot be transferred to the mother, and any weeks of sharable leave that must be taken by the father in order for the family to qualify for bonus weeks of parental leave" (OECD Family Database)

⁸ To improve comparability across countries, public expenditure is adjusted for price differences between countries by using purchasing power parities (PPP).

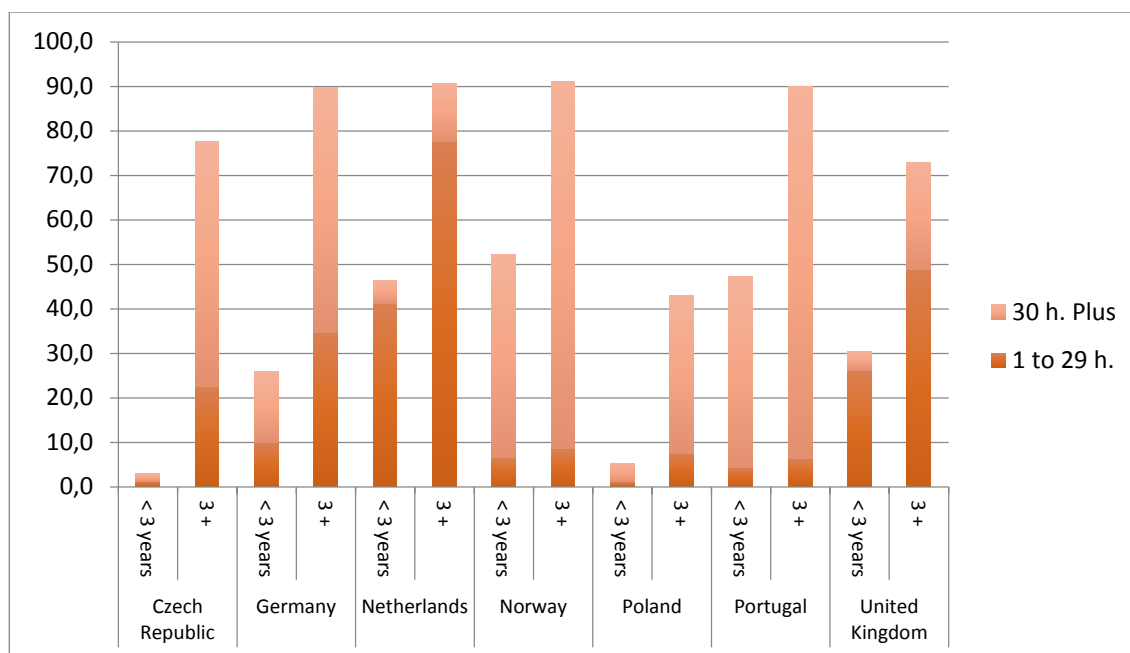
2.1.5 EARLY CHILDHOOD EDUCATION AND CARE ECEC

Formal Early Childhood Education and Care (ECEC) services can help address a range of family and child issues (OECD, 2016). ECEC provision is not only important for parents' labor market participation, but is also an important means to reduce social inequalities (Melhuish et al., 2015).

Figure 2.1.5.1 presents participation rates for children under age 3, and children aged between 3 and 5 years, by weekly hours. Participation rates for children aged between 3 and 5 years are relatively high in all countries. Participation rates in Germany, the Netherlands, Norway and Portugal are at around or above 90%. Rates for children under 3 tend to be lower, and differ considerably more across countries. In Norway, Portugal and the Netherlands around one-in-two children under 3 participate in ECEC, while in the Czech Republic and Poland, less than one-in-twenty children under 3 participate in ECEC.

When looking into ECEC enrolment rates, it is also important to consider the extent to which ECEC programs cover the working day, or provide services for only some hours a week (Eurydice & Eurostat, 2014). For both age groups (under 3 and aged 3-5), the UK and the Netherlands stand out with relatively low average weekly hours in centre-based ECEC (although this can be related with parents choice, as in the case of the Netherlands, where services are open all week. In contrast, in Norway, Poland, and Portugal, the vast majority of

Figure 2.1.5.1 Formal childcare by age group and duration - % over the population of each age group (2015)



children enrolled in ECEC spend more than 30 hours a week in ECEC (Figure 2.1.5.1).

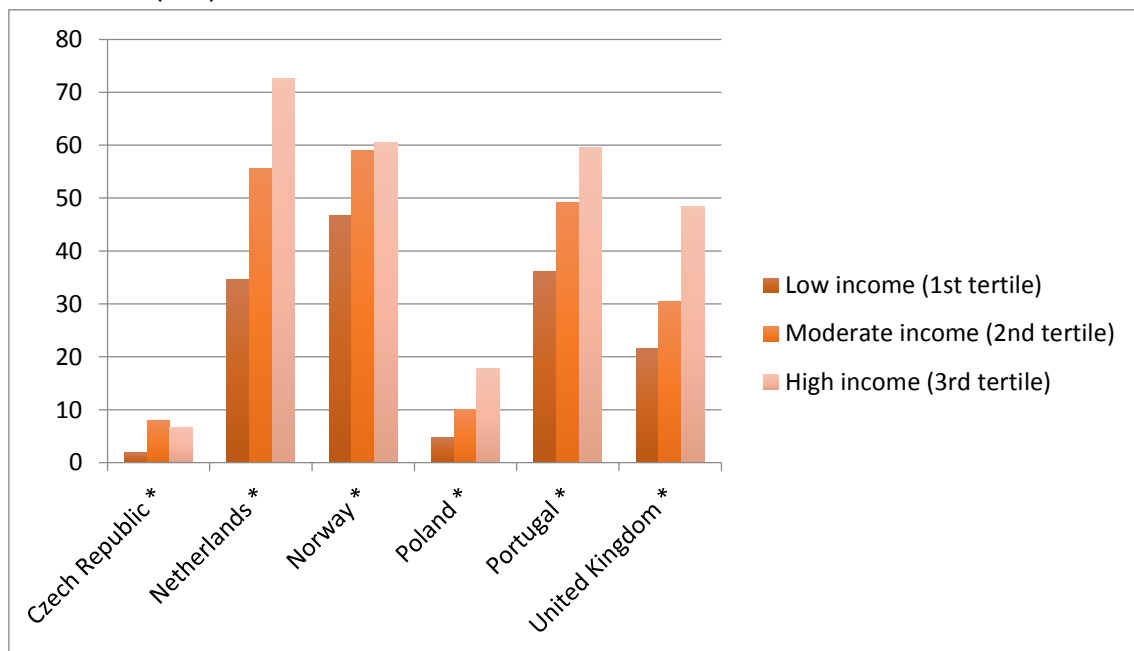
Source: EU-SILC survey. Percentage of children that attend formal childcare by two age categories (Less than 3 years ; From 3 years to minimum compulsory school age) and by duration (From 1 to 29 hours; 30 hours or over). Data from the year 2015 (latest available for the 7 countries).

Inequalities in the use of ECEC: In all countries, the use of formal ECEC for children aged 0 to 2 varies with family income levels (Figure 2.1.5.2). With the exception of Norway, children from high-income families are considerably more likely to use ECEC than children from low-income families. In UK and the Netherlands, participation rates for children from low-income

families, respectively, 22% and 34%, are around half of the participation rates for children from the high-income families (48% and 73%). In Poland and Czech Republic, although participation rates are fairly low across all groups of children, there are nevertheless differences: participation rates for children in low-income families (2% and 5%) are less than one third of the ones for children from high-income families (7% and 18%).

The OECD's Family Database did not provide information for Germany. Data for Germany was taken from Bildungsbericht 2016. The number of places in ECEC for children under the age of 3 years has increased over the last years in Germany as a consequence of the legal entitlement for a place for each child. However, it seems that these places are taken up more by higher educated parents. While the number of children in childcare under the age of 3 years with parents whose highest educational degree was ninth-grade was 19,0 % in 2012, it decreased to 16,4 % in 2015. Conversely, the proportion of children with higher educated parents has risen.

Figure 2.1.6.2 Participation rates for 0-to-2-year-olds in formal childcare and pre-school services, by parents' income levels (2014)



Source: OECD's Family Database (EU SILC). Data for Chart PF3.2.B. Participation rates for 0-to-2-year-olds in formal childcare and pre-school services, by equivalised disposable income tertile, 2014. Data include children using centre-based services (e.g. nurseries or day care centres and pre-schools, both public and private), organised family day care, and care services provided by (paid) professional childminders, and exclude those using unpaid informal services provided by relatives, friends or neighbours. Equivalised disposable income tertiles are calculated using the disposable (post-tax-and-transfer) income of the household in which the child lives – equivalised using the square root scale, to account for the effect of family size on the household's standard of living – and are based on the equivalised disposable incomes of children aged less than or equal to 12.

The provision of affordable ECEC services may also have an equity role to play (OECD, 2016). Costs vary across the participating countries. Figure 2.1.6.3. shows gross fees⁹ for two children (age 2 and 3) attending full-time care¹⁰ at a typical ECEC centre, as a percentage of average earnings¹¹. The costs differ considerably across the participating countries. In the

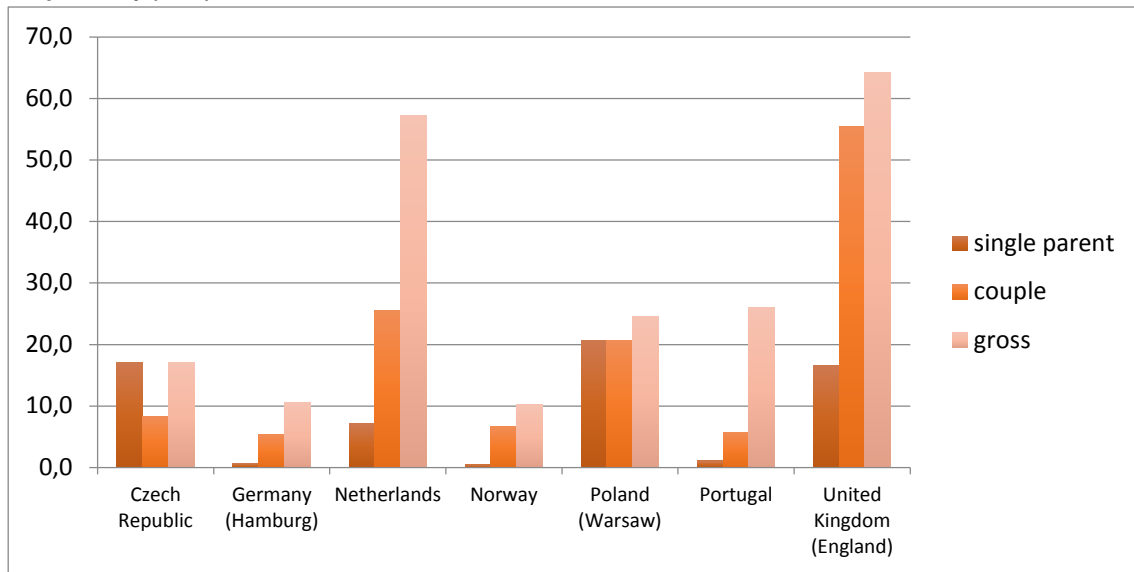
⁹ OECD Family database: Gross fees for two children (age 2 and 3) attending full-time care at a typical childcare centre, as % of average earnings

¹⁰ OECD Family database: Full-time care is defined as care for at least 40 hours per week

¹¹ OECD Family database: Average earnings refers to the gross wage earnings paid to average workers, before

Netherlands and the United Kingdom, levels of ECEC costs charged to two-earners families are relatively high, compared to the other countries. When taking into account the financial support (childcare benefits or tax reductions) provided to families, the out-of-pocket costs of full-time centre-based care¹² for two children (aged two and three) remain very high in the UK, accounting for around 55% of family average earnings. Although this percentage is substantially lower in the Netherlands, it is still comparatively high compared to the other countries, claiming an average of 25% of the net family income.

Figure 2.1.6.3 Gross childcare fees and out-of-pocket childcare costs for a single-parent family and two-earner couple family (2015)



Source: OECD (Family Database), retrieved (2017, october) from <http://www.oecd.org/els/family/database.htm>. Net childcare costs for a two-child (aged 2 and 3) single-parent family with full-time earnings at 50% of average earnings, as a % of average earnings (AW), 2015. Net childcare costs for a two-earner two-child (aged 2 and 3) couple family with full-time earnings at 100+67% of earnings, as a % of average earnings (AW), 2015. Gross fees for two children (age 2 and 3) attending full-time care at a typical childcare centre, as % of average earnings (AW), 2015.

deductions of any kind (e.g. withholding tax, income tax, private or social security contributions and union dues) (OECD, 2015)

¹² OECD Family database: Net childcare costs for a two-earner two-child (aged 2 and 3) couple family with full-time earnings at 100+67% of earnings, as a % of average earnings

2.2 OVERVIEW OF FAMILY AND PARENTING SERVICES IN EACH COUNTRY

This section provides an overview of available services for parents and families in each participating country. Parenting support refers to a set of activities aimed at improving how parents approach and execute their role as parents and at increasing parents' child-rearing resources (including information, knowledge, skills and social support) and competencies (Daly et al., 2015). In trying to understand the national contexts of policies and services that aim to support parents and families, it seems important to point out that even though direct support to parents is our main focus, wider policies such as health care, parental leaves, ECEC or early intervention measures, are equally important from a family perspective (Janta, 2013). Parenting support touches upon a wide range of areas of health, education and social care (Molinuevo, 2013), and therefore, in the country reports, a range of family-related services are also described, in particular those services aiming at improving parenting or family functioning for the ISOTIS target groups: i) families with multiple needs who do not meet the social care threshold; ii) families with immigrant background/non-native speakers; iii) Roma/ethnic minorities. Equality issues related to the conditions of access, targeted services and monitoring are also discussed. Finally, for each country, the current main challenges regarding parenting and family support from an equity perspective are presented and discussed.

2.2.1 COUNTRY PROFILE: CZECH REPUBLIC

Lenka Slepíčková

2.2.1.1 Services overall description

The services for children and families in the Czech Republic are governed by three broad groupings. These are: Ministries (especially the Ministry of Health, Ministry of Education, Youth and Sport, and Ministry of Labour and Social Affairs), Municipalities, and NGOs. The system of support is usually categorized into the following age groups: new-borns and toddlers: 0-3 years; preschoolers: 3-6; school age children: 6-15; adolescents 15-18; youth: 19-26).

MINISTRY OF HEALTH

Health care for children and youth, as well as primary health care in general, is organized at the district level. The care is free for children and paid for by an obligatory health insurance of economically active persons (citizens pay an insurance premium computed as a percentage of their income regardless of what healthcare they receive or will receive). Children are registered at the general practitioners for children and youth according to the choice of parents made before birth. While general practitioners usually provide the first visit at home after birth, breastfeeding support is provided by maternity hospitals. Certain health insurance companies also cover several sessions with a consultant for breastfeeding after birth (mostly in larger cities), and a network of private consultants for breastfeeding is available. General practitioners also provide obligatory vaccinations against infectious diseases, an important part of the Czech healthcare system. Until three years of age, there are 10 prevention health checks (introductory, and in the ages of 14 days, 6 weeks, 3 months, 4 months, 6 months, 8 months, 10 months, 12 months and 18 months). These visits include vaccinations, nutritional advice, investigation of the psychological and physical development, hearing examination (8 months), sight examination (4 months) and general general check of the sensory organs (18 months). From 3-18 years of age, there are periodical visits planned (at the age of 3, 5, 7, 9, 11, 13, 15 years, and the final one at the age of 18 years and 11 months). These visits include an assessment of parental care (screening for signs of abuse or neglect).

MINISTRY OF SOCIAL AFFAIRS

The Ministry of Social Affairs governs the state social support for families and sickness insurance, also covering maternity leave. Participation in sickness insurance by an employee is mandatory under the law. Participation in sickness insurance by self-employed persons is voluntary.

Maternity Cash Benefit (hereinafter referred to as the “MCB”) is a benefit intended to substitute the regular income and is granted to a woman, who gave birth to a child, for the period of 28 weeks of maternity leave. On the day, on which it should be recognized (6 or 8 weeks before expected date of birth), the individual must still be participating in the sickness insurance scheme or be covered by the protection period arising after the termination of an insured (self-) employment, typically amounting to 7 calendar days. For women whose insured employment ended during pregnancy, the protection period for the entitlement to MCB is equal to the number of calendar days corresponding to the duration of the woman’s last employment, up to a maximum of 180 calendar days. Another precondition for the entitlement to MCB is that, in the last two years prior to her entry under MCB, the individual must have participated in the

sickness insurance scheme for at least 270 days. A self-employed person shall be entitled to MCB provided that she fulfils the requirement of participation in the sickness insurance scheme for self-employed for a period of 180 days during the last year prior to her entry under the MCB. In addition, it is also required that the employee no longer works in the employment, no longer receives any salary or remuneration from this employment, or, if self-employed, no longer pursues self-employment. MCB can be provided for a period of 28 weeks to an insured woman who gave birth to a child, or 37 weeks to an insured woman who had multiple birth (2 or more children) and takes care of at least two children after the lapse of the 28-week period. The total MCB granted is to 70% of the daily assessment base¹).

The state social support for families is regulated by Act no.117/1995 Coll., on State Social Support, as amended. Under this Act, the following benefits for families are available:

Child allowance

Child allowance is a basic long-term benefit provided to families with dependent children. A dependent child up to the age of 26 years, living in a family with an income of less than 2.4 times the family's living minimum wage/level, is entitled to this allowance. The allowance is provided monthly on three levels, depending on the age of the child (up to 6 years of age: 20 EUR, from 6 to 15: 24 EUR, from 15 to 26: 27 EUR).

Housing allowance

Property owners or tenants registered as permanent residents in that property are entitled to a housing allowance of 30% (in Prague 35%) if family income is insufficient to cover housing costs and if family income is lower than the relevant prescriptive costs set by law.

Parental allowance

A parent who personally and duly cares for a child who is the youngest in the family is entitled to parental allowance. Parental allowance is provided until the total amount of 8,627 EUR is drawn. This amount can be drawn up until the child is 4 years of age.

A parent may elect the monthly amount of parental allowance and duration of provision with the condition that at least one parent in a family is a person participating in sickness insurance. The monthly amount of parental allowance is calculated using a daily assessment base for determining MCB or sickness benefit related to child's confinement or adoption according to the act on sickness insurance. A parent is entitled to parental allowance provided:

- a child under the age of 2 years attends a crèche or other facility for pre-school children for a maximum of 46 hours a month;
- a child attends a remedial care centre, crèche, kindergarten or similar facility for disabled pre-school children for no more than 4 hours a day;
- a child of disabled parents attends a crèche, kindergarten or similar facility for pre-school children for no more than 4 hours a day;
- a disabled child attends a crèche, kindergarten or similar facility for pre-school children for no more than 6 hours a day.

The parent's income is not tested; the parent may carry out an occupational activity without losing their entitlement to parental allowance.

Birth grant

This is a one-off benefit for low-income families to help them to cover costs related to the birth of their first child and second live-born. Families are entitled to the birth grant provided the family income in the calendar quarter prior to the birth of the child does not exceed 2.7 times the family's living wage. The birth grant amounts to 510 EUR for the first child and 392 EUR for the second child.

The following services in the category of social prevention services in the Act 108/2006 Coll., are relevant for ISOTIS target groups (socially disadvantaged families):

Early care intervention

Early care is the social service for families with children under 7 years with a physical or mental impairment or in a chronic health condition. The service aims to support the family and the development of a child with special needs. The service helps with education, inclusion, provides informational support. The service is free and is provided by the centres of early care (mostly run by NGOs) or special education centres.

Asylum houses

Asylum houses provide temporary accommodation to persons in a difficult social situation relating to a loss of permanent housing. This service includes food and specialized social counselling, i.e. an assistance with claiming and the rights of the clients, and the mediation of contact with institutions. This service is paid, but the fee is limited by the law.

There are also shelters for women, mothers and children, run mostly by charities or NGOs in the Czech Republic. These shelters offer temporary accommodation to such people who have no other option of housing, and often are the victims of domestic violence (some shelters do not have a public address in order to protect them). The women and mothers are supported psychologically and socially, and trained in parenting skills. The clients are also offered a safe environment with social counselling and various activities.

Night dormitories

Provide accommodation to homeless persons including facilities for personal hygiene. This service is paid, but the fee is limited by law (it is usually in range of 1-3 EUR/night).

Social activation services for families with children

The aim is to support families who are in a long-term critical life situation (financial problems, housing or health problems, low level of education, addictions, unintended pregnancies, domestic violence etc.), that can endanger the healthy development of children and even result in the court orders and the institutional care for the children. The aim is to ensure that the children will grow up with parents in a safe and stimulating environment through professional support and long-term assistance, and become responsible for dealing with difficulties and challenges. The service is free and includes the long-term and regular cooperation with a social worker, based on the needs of family (case management approach).

MINISTRY OF EDUCATION, YOUTH AND SPORT (including ECEC)

Czech parents, mostly mothers, usually take care of the child personally (being supported by

maternity leave in the first months and by parental leave until their child is four years old). Mothers usually return to work (full-time jobs mostly) when the children are 3 years old. Increasingly, more mothers are interested in non-familial care for children younger than 3 years (because of demographic, economic and social conditions), but these intentions are kept back by deficiency of day-care and early childhood education facilities.

The dominant type of Early Childhood Education and Care (ECEC) facilities are kindergartens for children from 3 to 6 years, run by municipalities, operated according to the Education Act and listed in School Registry. The enrolment rate is about 80 % of children (almost 100 % in the last, compulsory grade). Attendance is free; parents pay just for meals and cultural and social activities, and these fees are relatively low. Attendance is compulsory in the last grade (before entering primary school) from September 2017. The placing of all children in this grade must be secured and must be completely free. The kindergartens are mostly run by municipalities or counties (in the school term 2015/16, it was 93 % of all kindergartens), whilst some are run by the private sector (6 % in the school term 2015/2016) or by churches (1 % in the school term 2015/2016). There are also private playgroups or nurseries (paid for exclusively on a commercial basis), run by companies (employers of parents) or other private institutions, but they are not many, and they are not controlled by the Ministry of Education as they are not part of a school system. From the term 2020/2021, it will be obligatory for kindergartens to accept also children older than 2 years.

Currently, there are only paid private facilities on commercial basis for children under 3 years old, as “Traditional” nurseries working as medical institutions (managed by Ministry of Health) ceased to exist in 2012 (their legal status was changed) – however, they only partly covered the demand anyway. The nurseries were not sufficiently replaced by other forms of care of children under 3 years of age. Individual paid care (au-pairs, nannies) is used by less than 5 % of families.

For Roma children and children living in deprived areas, there are playgroups run by NGOs or preparatory classrooms, adjacent to primary schools. They have been managed by the Czech Ministry of Education, Youth and Sports since 2000 and became part of the School Act as a legally guaranteed supporting measure for socially disadvantaged children as well as for children with learning difficulties. Their aim is mostly to teach the Czech language and to prepare the children for the regime of compulsory primary education (hygiene habits; basic and fine motor skills; the ability to follow classroom rules, internalization of a structured and regular character of different activities; socio-emotional skills; self-regulation etc.). They should help to improve integration of a child to the first-grade collective and to prevent school failure at the very beginning of a child's school career. Statistics from the school year 2015/2016 show 4514 enrolled children. Only children who are socially disadvantaged (confirmed by the Educational and Psychological Counselling) and who had postponed enrolment to the first class are eligible.

Before- (open mostly from 6.30 am) and after-school (open mostly until 4 – 5 pm) clubs are mostly run by primary schools and they are intended for children from 6 to 12 years. They are situated in schools, offer various activities, and are used by a big percentage of families, as the end of school hours is much earlier than the end of their work day (and the majority of Czech parents work full-time). The fee is very low. For children from disadvantaged groups, there are after-school clubs run by NGOs, providing also extra lessons, assistance with homework etc.. These are mostly situated in deprived areas.

The services for families are provided mostly by the public sector or by NGOs. The commercial subjects are entering the field of ECEC, but as the fees for attending the private kindergartens are high, they are used only by the minority of families. The most part of primary health care is provided by commercial organizations, but as it is paid by obligatory health insurance, for the consumers it plays no role.

Nationally, the most important NGO working with the disadvantaged (mostly Roma) families is People in Need. In many deprived areas, they run programmes for such families as following (following description in adapted from the web pages of People in Need NGO, available at: <https://www.clovekvtisni.cz/en/what-we-do/social-work-in-the-czech-republic>):

- Family consultations: The objective of family consultations is to search for, motivate, provide social assistance and give advice to families with children living in a difficult social situation that excludes them from the rest of society. The purpose of providing these services is to help families with issues they cannot resolve by themselves, which have a negative impact on the family environment and the development of the child. A long-term and intensive cooperation is emphasized, as well as an individual social assistance with standing up for one's rights and legitimate interests and honing parental skills.
- Tutoring: This service is intended for children who are having problems at school and suffer from a lack of support at home. The reason for this is primarily because their parents have a low level of education. Usually they completed only elementary school. The purpose of this service is primarily to stop children from performing poorly at school, although tutoring also brings many other positive effects. Tutoring, both individual and group, is mostly performed by volunteers. One example of these effects is a rise in the child's interest in school, which usually reduces the number of missed classes and increases activity during lessons.
- Low threshold clubs: Low threshold clubs exist for different age groups. With children (6 - 13 years of age) the work of club is concentrated on eliminating truancy. The clubs also represent an alternative to classic afterschool activity clubs which the socially disadvantaged families cannot afford, and are a place where they can do their homework. With youth (14 - 18 years of age) they focus on discouraging premature school drop-out, which usually results in resignation of ambition for a higher level of education. With all age groups, they address the problem of exposure to addictions and their prevention (alcohol, drugs and gambling).

Locally, there are many NGOs offering similar in-service support in deprived areas. An interesting activity run by a NGO called "Women for Women" is the project "Lunches for children" providing free school lunches for children whose families are in a difficult social situation (the families can participate in a project on the basis of a referral from teachers or headmasters). The positive results of this project are seen not only in better nutrition of such children, but also in improved school attendance and social inclusion. Since March 2017, this project cooperates with the Ministry of Social Affairs who partly contributes to this help. Since 2013, free lunches were provided to ca. 10,000 school children (for more information, see <http://www.obedyprodeti.cz/o-projektu>).

2.2.1.2 Equality issues (regarding ISOTIS target groups)

2.2.1.2.1 Differential access to services

In the field of services for children and families in the Czech Republic, there are universal services (no condition of access) that are provided for free; services with limited access or income tested; or services provided for a fee (that is, as in case of the social prevention services, regulated by Law). Here is the summary of the fees and type of access to the services described in a previous section:

- Primary health care for children – universal, no conditions of access.
- Breastfeeding consultation – partly universal (consultations covered by health insurance), partly on a commercial basis.
- Sickness insurance – only for officially employed persons or self-employed, who are willing to pay for it.
- Maternity leave – strict conditions regarding the previous employment career of a woman (see previous section).
- Child allowance – income tested, available for a big proportion of low income families.
- Parental allowance – universal.
- Housing allowance – low income families, but as the conditions are quite strict (the 3-month rent must have been paid etc.) and sometimes prevent efficient help.
- Child grant – income tested, available to a big proportion (one third) of low income families.
- ECEC for children under 3 – almost non-existent in the Czech Republic, provided on a commercial basis and unavailable for most families as the fees are high.
- ECEC for children aged 3-5 – there are fees, for some Roma families this service is unavailable. Access is limited also by a general lack of places in kindergarten and by cultural reasons (it is common to rely exclusively on family care in Roma communities, it is not common to use the service located far from the place of living, etc.).
- ECEC for children from 5 to 7 - access is universal and guaranteed by law. In practice, there are many kindergartens informally “refusing” Roma children by referring parents to the segregated preschool institutions such as preparatory classrooms (information from the stakeholders from the NGOs).
- Preparatory classrooms - only children who are socially disadvantaged (confirmed by the Educational and Psychological Counselling) and who had postponed enrollment to the first grade are eligible.
- Before and after school clubs – the fees are low, but they can (in combination with cultural factors mentioned above) still prevent the attendance of Roma or low-income children.
- Early care intervention – no fee, universal access.
- Asylum houses – low fee, access is limited by places available.
- Night dormitories – low fee, access is limited by places available.
- Social activation services for families with children – free.

2.2.1.2.2 Targeted Programmes

1. Child allowance – Low-income families
2. Child grant – Low-income families

3. Housing allowance – Low-income families
4. Preparatory classrooms – For Roma and socially disadvantaged children

Social activation services and other services and programmes run mostly by the NGOs are often targeted services for low income or Roma families.

2.2.1.3 Monitoring

The external evaluation of other services is rare, the services are evaluated mostly within the organisation providing them on the basis of various criteria. The services run by the Czech Ministry of Education are evaluated by the Czech school inspection on a regular basis.

2.2.1.4 Language

The language support is provided only in preparatory classrooms for Roma children or in tutoring programmes, but it is a support in the language of instruction (Czech language), not in Roma languages.

2.2.1.5 Main challenges

1. The system of ECEC and its usage follows a very strong pattern in the Czech Republic (no ECEC care facilities and 100 % of time spent with a primary caregiver until 3 years, and the whole day 5 days a week in an institution from 3 years, as both parents are working full-time), preventing parents to employ more flexible strategies of combining care and paid work. Almost no ECEC institutions for children under 3 are available and other forms of care are rare or expensive.
2. The preparatory classrooms can lead to the segregation of Roma children in preschool age. At the moment, their existence is sometimes used as an “excuse” for the mainstream kindergarten headmasters who are not willing to accept Roma children in their classes, not even in the compulsory, last year of attendance (and they refer parents to the segregated preschool institutions instead - an information from the stakeholders from the NGOs working in the field). The preparatory classrooms do not support the Roma language competencies of children.
3. Certain social benefits (Housing allowance or Maternity leave) underlie such strict conditions (type of rent or connection to the previous employment and income) that in practice they are not helping the families in need.
4. NGOs are operating mostly within temporary projects (in terms of funding), so their help cannot be consistent or developing well. They work in an insecure situation as at the end of a financial year they often do not know the budget for the next year.

2.2.2 COUNTRY PROFILE: ENGLAND

Katharina Ereky-Stevens, Maria Evangelou, Rebecca Tracz, Bethan Thomson

2.2.2.1 Services overall description

Services for young children and families with young children in England are provided through local authorities, and focus commonly on the 0-5 age-group, thus on children (and their families) before school-age. Local authorities are funded by various government departments, including health and education. Government departments provide guidelines on the provision of services; within those guidelines local authorities are given flexibility in making decisions on how funding is spent, to provide services that meet local needs. In addition, local authorities are also required to work together with 'third sector' (NGO) and private sector organisations, during the planning and delivery of services. The private sector for example provides a significant proportion of all full day care for younger children (see section 1.3), and NGOs play a role in managing and/or financing some (often targeted) services for young children and their families. In addition, NGOs increasingly focus on ICT as a means of providing parent support in the form of providing multi-media information materials, parenting advice (e.g., calming a crying baby, setting rules, family benefits) and forums to meet other parents and exchange information (e.g., <http://www.parenting.co.uk/>; <https://www.familylives.org.uk/advice/>; <https://www.familyandchildcaretrust.org/childcare-guides>).

Different sectors work together, and the extent of co-operation and overlap depends on the sectors and organisation of services within local areas. The aim is to integrate and join up services on offer – with health and adult services as key partners, but also including Play services, Childcare, Social care, General Practitioners (GPs; they are family doctors), NHS Trusts, Police, Youth Services, Job Centres, Housing etc. Services described in this overview are: i) public health services for young children (0-5) and their parents; ii) children's services (including children centres and social care/child protection services); and iii) early childhood education and care.

Public health services for young children (0-5) and their parents

The public health sector in England aims to support local authorities and the National Health Service (NHS) in securing health and wellbeing, with a focus on reducing health inequalities through evidence-based interventions. Funding for the NHS is the responsibility of the Department for Health. Clinical commissioning groups (CCGs) are responsible for the planning and commissioning of healthcare services for their local area. CCGs are clinically led statutory NHS bodies; CCG members include General Practitioners (GPs) and other clinicians, such as nurses and consultants. Thus, it is local authorities who have the full responsibility for commissioning public health services for children up to the age of 5. The local authority must also ensure that commissioning for children aged 0-5 is joined up with other relevant local services, i.e. those commissioning for 5-19 year olds.

In 2009, the Department of Health set out an evidence-based programme of best practice – to develop improvements in health and wellbeing for children and young people. The Healthy Child Programme (see Shribman & Billingham, 2009; Department of Health, 2009) was designed to bring together health, education and other key partners to deliver programmes for prevention and support for families with children between the ages of 0-19. Here we focus on the Healthy Child Programme – Pregnancy and the first five years of life (Shribman &

Billingham, 2009). A major emphasis of the newly revised programme was on parenting support, with a priority towards integrated services and an increased focus on vulnerable children and families (Shribman & Billingham, 2009).

The programme aims to help parents and children to develop and sustain healthy and secure relationships; to promote physical health (through screening and immunisations, and by promoting healthy life-styles; encourage care that keeps children safe and healthy; and make sure that all children are prepared for and supported in child care, early years, and education settings, as well as being 'ready to learn at two and ready for school by five' (Public Health England, 2016, p.6).

Public health teams are usually located in health centres/local clinics, and public health services for young children and their families can also be delivered in/from local children's centres.

Public health visitor/nursing services are key in supporting the delivery of the local authority's early help and intervention system (Department for Communities and Local Government, 2016) and targeted services such as the 'Troubled Families Programme' (see section 1.2).

Health visitors are trained specialist community public health nurses. Wider health visiting teams may also include nursery nurses, healthcare assistants and other specialist health professionals. Health visitors will work in close partnership with midwives and GPs, and also with a range of local services that deal with more complex problems over longer period of time i.e. Universal Plus, and Universal Partnership Plus services. Health visitors may have a role in community asset mapping, identifying whether a particular community has specific needs. By offering support through working in partnership with other professionals, for example staff working in children's centres, they can help communities to help themselves.

Health visiting teams provide expert advice, support and interventions to all families with children in the first years of life, through home visits and in community clinics and centres. The core public health offer for all young children includes child health surveillance and development reviews (e.g., baby clinics, 1-year assessment); child health protection, immunisation and screening; information groups (e.g., ante-natal classes, breastfeeding support groups, courses on introducing solid food to babies), and information materials (including information on child development, parenting issues and challenges, child care and education services, and on health life styles)¹³. Health visiting teams identify the needs of individual children, parents and families (including safeguarding needs), and have responsibilities in identifying problems early, and to respond when specific expert help is needed. Health visiting teams organise practical support (for example working with a nursery nurse on the importance of play) and refer to existing local services, thereby promoting early interventions. They communicate (together with parents) with partners (e.g., children's centres, early years services) and offer access to support groups, such as those delivered by children's centres. Health visiting teams may also refer to 1) parent intervention and specialist services, i.e. speech and language therapists, and health visitors or community midwives may refer to or the Family Nurse Partnership Intervention Programme; and 2) additional or targeted public health nursing support (e.g., support for looked after children) (Public Health England, 2016; NHS England, 2014; NHS choices, 2016). Examples of the types of universal and targeted support are

¹³ Including (multi-media information provided online -

presented in Diagram 1.1a. Diagram 1.1b shows the types of support and health focus in terms of developmental stage through pregnancy, up until 5 years. Please note that the full diagram (up to 19 years) can be accessed via the link.

Diagram 1.1a Healthy Child Programme (HCP): best start for all children and extra help where needed. (Hoskin, A., n.d.,)

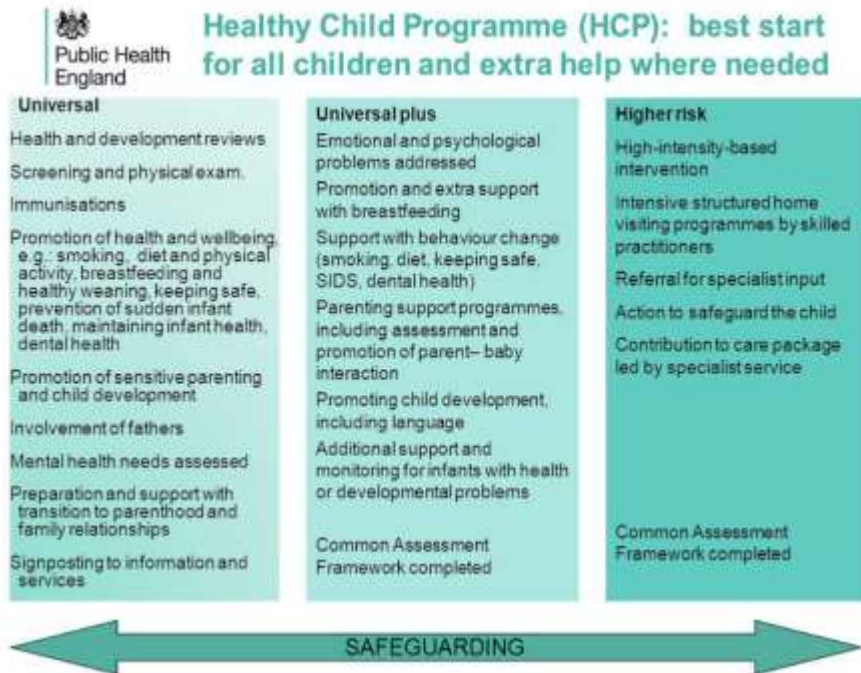
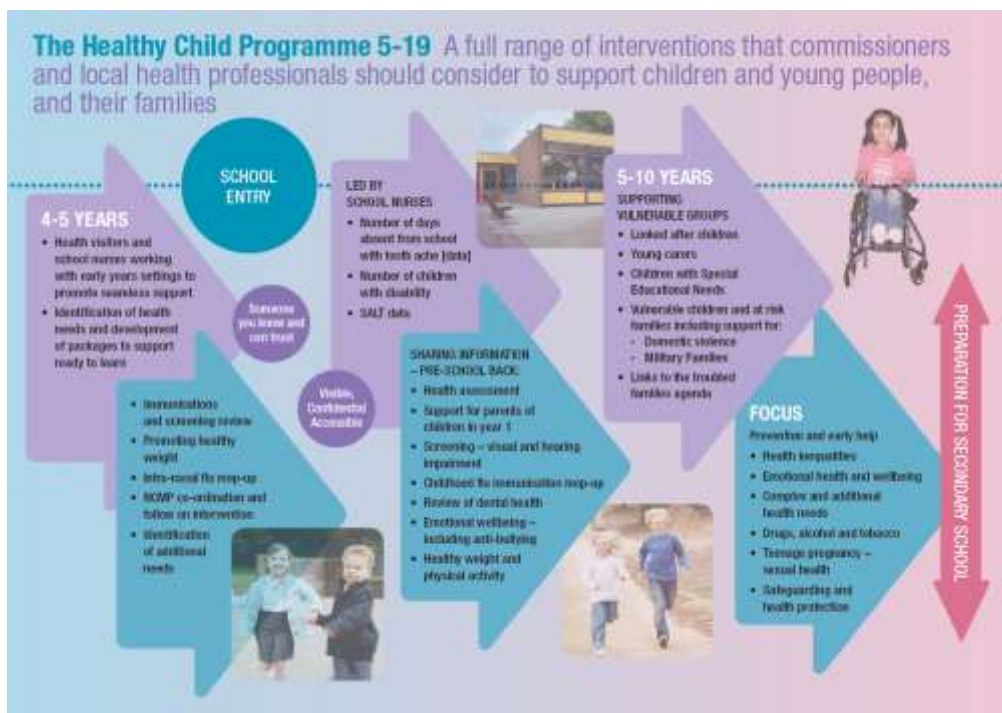


Diagram 1.1b The Healthy Child Programme 0-5; Bennet (2015)





Family and parenting support provided through local authorities

Family and parenting support provided through local authorities aim to promote the wellbeing of families in the local area, through strengthening parent capacity and improving family life. The mission is to cater for local needs and tailor provision to the multiple needs of families.

All local authorities now offer a Family Information Service, parenting programmes, one-to-one support and intensive family intervention services. Services provide parents with information and advice on parenting, getting back into employment or education, housing, finance or childcare and education. A multi-agency approach is increasingly being taken to address parent and family needs. Integrated and joined up working – with health and adults’ services as key partners – is increasingly the norm for at least the last 10 years.

In all local authority areas, a broad offer of universal services is complemented by targeted services, for 1) families identified to be in need of additional or specialist services (e.g. Parent Partnership services, Family Learning, Parent Support Advisers in schools); 2) families needing more structured and intensive support (e.g. Think Family Parenting Support and Programme, Family Nurse Partnership); 3) families most at risk (Family Intervention Services). Family and parent services are mainly delivered through Sure Start Children’s Centres, Children and Family Centres, Intervention Centres (Hubs) and extended services around schools.

The goal of **Sure Start Children’s Centres** is to enhance the health and development of children in England under the age of five, with a particular focus on those families at risk/low income families. Their specific remit is to “improve outcomes for young children and their families and reduce inequalities, particularly for those families in greatest need of support” (Department for Education, 2013, p.6). They make available universal and targeted early childhood services either by providing the services at the centre itself or by providing advice and assistance to parents and prospective parents in accessing services provided elsewhere. To ensure that existing public services work together to improve child outcomes, children’s centres provide a range of integrated services, such as health and family support, as well as childcare

and early years education. Programmes are mainly run by centre staff, although other organisations may be involved (e.g. adult education such as ESOL), and the intent is that there is close cooperation with social workers, health visitors, midwives, and ECEC providers.

Children's centres have a broad remit of provision. Services are designed to include outreach/home services; support for good quality play, learning, and childcare experiences for children; primary and community health care; advice to parents about child and family development; and support for people with special needs including access to specialised services. A mix of evidence-based programmes (e.g., Triple P) and non-evidence-based programmes (e.g., Baby Massage) are often accessible through children's centre services.

Local authorities, in cooperation with partner agencies, contribute also to the assessment and service provision of parenting support through **child protection services** which aim to support family functioning and child development for families with vulnerable children (children who need or are receiving targeted and/or specialist help from local authority children's services).

Assessment of needs and support can be directly provided by social workers (in cooperation with family support workers and key workers), or through referral to intervention agencies and other services. When parents are facing complex, multi-layered problems, an integrated package of support is tailored to meet the needs of each member of the family following assessment. Services for families with multiple needs include the 'Troubled Family Programme'; evidence-informed interventions including intensive family intervention projects, or systemic social work practice; targeted early help service to improve parenting or family functioning (e.g., Triple P, The Incredible Years, Strengthening Families, Family Nurse Partnership); and community based social work teams, working with families at all levels of need. Local authorities increasingly put multi-agency arrangements in place (e.g., multi-agency safeguarding hubs – 'MASH'), and some offer 'one front door' which accepts both – referrals for early help and those for social care.

Finally, with regards to ISOTIS target groups, local authorities offer services such as 'The Traveller Education Service' or the 'Ethnic Minority Achievement Service': those teams support and advise schools/settings on how to help children settle into school and to maintain and continue education, how they can meet the needs of pupils learning English as an additional language (e.g. carrying out assessment/progress monitoring of children, advice and guidance on resources, teaching and learning, supporting parent partnerships, bilingualism).

Early childhood education and care (ECEC)

The mission of ECEC services in England is to maximize the positive impact of ECEC attendance on child outcomes through the offer of good quality ECEC to all children. This commitment is part of the wider national policy agenda to reduce poverty and increase social mobility, as well as a wider EU co-operation on addressing access and quality of ECEC in Europe. ECEC services in England are partly financed by the state (Department for Education) and partly financed by private individuals and organisations. Services are offered through private/voluntary/parent run settings, schools, and children centres. Staff requirements vary by provider and age of the children from teacher training (reception room classroom), early years professionals, and staff with varying levels of early years training.

Diagram 1.3a Names and Types of Early Childhood Education and Care Providers, England



The system of ECEC provision is complex, and different providers vary in their focus on care or education, opening times, and the source of finance. The system however is unified by the fact that all types of registered ECEC provisions for all age groups are organized under one integrated system – the Ministry of Education; and by a national curriculum framework, the Early Years Foundation Stage curriculum (EYFS, introduced in 2008 and revised in 2012; DfE, 2014) which applies to all registered providers, and seeks to ensure a more even quality and consistency across all early years settings in England, with the aim that *all* children are well supported in their learning, get equal opportunities and get a good foundation for their later education.

The EYFS requires educators to offer activities and experiences in seven areas of learning: The prime areas – communication and language, physical development, and personal, social and emotional development – which are emphasised particularly in the early years, with a gradual shift towards an increased focus on four specific areas (literacy, mathematics, understanding the world, expressive arts and design). The document is grounded in developmentally appropriate play-based practice (Nutbrown, 2012), and the main characteristics of effective learning and teaching are described as playing and exploring, active learning, and creating and thinking critically. The importance of purposeful play and a good balance between child-led and adult-initiated activities is emphasised for curriculum implementation. Positive relationships and enabling environments are seen as the basis of child well-being and development and the importance of partnerships with parents is underlined. One of its overarching principles is that children learn and develop well in enabling environments where there is a strong partnership between practitioners and parents and/or carers. Guidance materials on assessments describe a process in which parents and practitioners work in partnership to draw up a clear picture of the child’s development, and to identify learning priorities for the child and support learning at home.

2.2.2.2 Equality issues (regarding ISOTIS target groups)

Public health services for young children (0-5) and their parents

Delivery of the Healthy Child Programme to every child demonstrates intent to tackle health inequalities and provide a healthy start for every child. Public health services are available to all

UK citizens for free. The Healthy Child Programme is based on a model of progressive universalism, with more intensive/extensive work for families identified to have additional needs or vulnerability to poor health outcomes. The recommendation is to carry out local needs assessments to identify sub-groups in the community (including refugees and migrants), detailing the actions required to address their needs (Renton, Hamblin & Clements, 2016; Public Health England, 2016).

All children and families who are resident or attending school in the local authority area should receive the Healthy Child Programme. The public health service is mandated by the government to carry out the key child developmental reviews (ante-natal health visit; new baby review; 6-8-week assessment; one-year assessment; 2-21/2 year review). This ensures provision of the reviews in the context of a national, standard format, thus supporting universal coverage and families' overall wellbeing (Department of Health, 2015).

In order to access the full service, registration with a local GP-surgery is necessary. Data of each registered person are kept electronically, and can be accessed (with some restrictions) across different NHS providers (contact information, dates of birth, health-related information from previous appointments and treatments). Registration with a local GP-surgery aims to ensure that pregnant mothers, mothers of young infants, and infants and young children who are registered with a GP, receive reminders and appointments to be seen for health check-ups and vaccinations the time/age they should take place. Families are contacted with reminders about upcoming health checks and vaccinations. Services are voluntary, but there is an expectation that families will take-up services routinely offered to everyone. To encourage this, the NHS provides i) detailed information on all services on offer on their website and in flyers (including for example information on vaccination myths); ii) personalised calendars to download that highlight the dates particular interventions or check-ups are due. Translation services are offered to ensure better access and better-quality services for families with language backgrounds other than English.

While public health services work under the principle of equal access for everyone, research indicates that refugee and migrant families face barriers to accessing services, including confusion around entitlement and registration requirements among families and staff. There is limited information on shaping the Healthy Child Programme 0-5 so that it meets the specific needs of refugee and migrant children (Renton, Hamblin and Clements, 2016).

Family and parenting support provided through local authorities

Services run by the local authorities include open access and universally available services, through specialist provision to more structured, targeted and intensive support. Local authorities offer a mixture of free services and fee-paying services. Each local authority provides a 'Family Information Directory' online, a database that shows all services offered in the local areas. Depending on the needs of the family, services are accessed either through self-referral or through professional referral services.

With the aim to increase equality between families, the focus is on low income families and families at risk. Services are commonly delivered through Children's centres. These centres were originally built in economically-disadvantaged areas, designed to serve populations within the locality, to reduce the gap in outcomes between poor children and their more affluent peers, to increase school readiness, and (with the expansion of children's centres into other areas) to ensure that there are opportunities for social class mixing. While they were later extended to a

wider area (also including not specifically disadvantage areas), children's centres are currently facing cuts, and services are closing down and have now dramatically reduced. This again led to a focus on sustaining services in the more deprived areas.¹⁴

Children's centre services are available to families living in the area. They are free to attend, and users can voluntarily access provision, by self-referral. Children's centres offer a mix of universal and targeted services for families identified to be in need of support. 'Targeted' users are children (e.g., with additional needs, speech and language delay, challenging behaviour); parents (e.g., with mental health problems, parenting challenges); families (e.g., who are workless, in social isolation, in poor housing); and specific groups (e.g., teen parents, lone parents, Black and Minority Ethnic groups (BME groups), families with immigrant background, or dads. Families in need of targeted support are identified through outreach, information sharing across services, referrals and casework, early intervention approaches, engagement with families through universal services, outreach, and local knowledge (Lord, Southcott & Sharp, 2011).

Family and parenting support provided through child protection services is targeted for multiple-risk families in need. Referral to those services is usually professional, and families get a referral for intervention after assessment provided by social workers (who often work together with the health or early education services, e.g., for identification of children/families in need of assessments). Participation in programmes offered to parents is voluntary at the stage of early help.

Early childhood education and care (ECEC)

As part of the wider national policy agenda to reduce poverty and increase social mobility, the mission is to increase availability and quality of ECEC provision, and thus to offer good quality ECEC to all children. ECEC services vary in terms of free access and fees. A *universal offer of free ECEC* is made to all children attending pre-primary education (30 hours/week during the reception year, the year before Year 1 in Primary School) and to all three- and four-year-old children attending ECEC before entry to reception (15 hours/week currently being increased to 30 hours/week). *Targeted free access* is offered to 40% of the most disadvantaged two-three-year-olds (15 hours/week). Outside these free entitlements, parents carry the costs of ECEC, and those costs for parents are comparatively high in England (Department for Education, 2017).

The Department for Education (2015) reports that 98% of 4-year-olds and 92% of 3-year-olds, were accessing their free entitlement to early education, however, only 58% of 2-year-olds eligible for a funded place in ECEC were utilising this offer. Some data indicates that the socio-economic status of families affects the uptake of free entitlements (Mathers & Ereky-Stevens, 2017).

2.2.2.3 Monitoring

Public health services for young children (0-5) and their parents

The new Public Health Outcomes Framework was introduced to provide transparency and

¹⁴ (a detailed review of what is currently offered by children's centres will be published in autumn 2017, by the Sutton trust and the University of Oxford)

accountability across health services. It introduces the overarching vision for public health, including outcome aims, and indicators that help us to understand how well services are performing in terms of improving health and wellbeing; technical details of public health indicators are also made available. A third part considers the impact assessment and equalities impact assessment. Importantly, this system is focused around achieving positive health outcomes for the population as well as reducing inequalities in health, rather than focusing on process targets or the performance management of local areas.

The Public Health Outcomes Framework focuses on two outcomes, increased healthy life expectancy, and the reduction of differences in life expectancy between communities. A set of supporting indicators have been developed to help focus an understanding of how well services are doing. The indicators which have been included cover the spectrum of 'what matters most' in public health, and help to improve in specified outcomes (Department for Health, 2012). The framework includes a large number of indicators on children and young people's health and, along with the NHS Outcomes Framework, set a clear direction for children's health.

NHS England developed the health visitor service delivery metrics, which cover the mandated child development reviews and report on a number of indicators (e.g., number of mothers who received a face to face antenatal contact, percentage of new birth visits completed, percentage of 12-month development reviews completed) (Department for Health, 2015). All providers of publicly funded community services are mandated to collect and submit community health data. This data is reported in the Children's and Young People Health Services Dataset (which is currently being renamed into the Community Service Dataset)¹⁵.

Local authorities (in partnership with health and wellbeing boards) have the responsibility to demonstrate improvements in public health outcomes, through achieving progress against the indicators which best reflect local health needs. Public Health England has responsibilities to publish national and local data, on progress, against the outcomes. Data collection processes are in place to report on the coverage and up-take of services part of the Healthy Child Programme. Data are published on the indicator measures include the disaggregation of data to local authority level, and by key equality and inequality characteristics. Public Health England also publishes tools that support benchmarking of outcomes between and within local areas to provide insights into performance.

Electronic records are kept in the Child Health Information System (CHIS) to enable data collection to support the delivery, review and performance management of services. Providers are expected to highlight where there is an absence of local services for onward referral to more specialist support. The expectation is that this information will assist local leaders in developing and implementing their strategies to improve health and wellbeing, and the wider public as they seek to understand how well their local services are supporting them (Department of Health, 2013).

In addition, independent research is conducted by some university and research centres to assess the up-take of services (e.g., research conducted by University of Bristol on the up-take of the Healthy Start Programme)¹⁶.

Providers are also required to undertake reviews to ensure they are suitable for local need and meet the quality indicators (Public Health England, 2017).

¹⁵ <https://digital.nhs.uk/Community-Services-Data-Set>

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Family and parenting support provided through local authorities

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to support high quality care of children and young people, in education and skills for learners of all ages. Ofsted inspections provide an independent **external evaluation** of the effectiveness of many services offered through local authorities, including council children's services.

The inspection of children's centres by Ofsted checks if i) centres know their community and deliver services most needed, to a high standard; ii) if services have good partnerships with health- and employment services, childcare providers and other relevant services. Inspectors make judgements on the overall effectiveness; access to services by young children and families; action/development plans; the activity programme; any evaluations carried out of services or activities, or other evidence of impact of the work of the centre; performance tracking data and other management information. An inspection will either be of a single centre, or of a children's centre group that offers integrated services and shares leadership and management. Where possible, inspections will be carried out across a locality where organisations deliver services collaboratively (Ofsted, 2014; Ofsted, 2015a).

In addition, family and parenting support services are **internally monitored**. Many local authorities are developing their own outcome frameworks, performance measures and data collection processes to better understand the system in which family support services operate. Intervention centres are usually required to produce annual reports on services on offer, attendances, number of referrals, performance on measures of implementation of standards, etcetera. Self-assessment tools are available. In 2007, the National Centre for Social Research established a secure web-based information system for project staff to record details of the families they worked with at various stages of an intervention. The system was in place until 2011, and based on this data, the Department of Education reported on service capacity and service engagement, and outcome measures, including for example family functioning, health and education (Department for Education, 2011).

Few local authorities undertake a formal evaluation of the practices and approaches that are being used locally. However, some projects, which have been funded by the Department for Education or the voluntary sector, are attempting to demonstrate impact through rigorous research. Between 2009 and 2015 for example, the six-year Evaluation of children's Centres in England (ECCE) study was conducted by NatCen Social Research, the University of Oxford, and Frontier Economics. The aim of ECCE, a project commissioned by the Department for Education, was to provide an in-depth understanding of Children's Centre services, including their effectiveness in relation to different management and delivery approaches and their cost. The evaluation included 5 strands, a survey of children's centre leaders; a longitudinal survey of families using children's centres, an investigation of children's centre service delivery and reach; an impact analysis of the effects of children's centres on child, mother and family outcomes; and a value for money analysis.

Early childhood education and care (ECEC)

OFSTED inspections monitor structural as well as process quality (compliance with regulations and minimum standards, staff training and working conditions, curriculum implementation, pedagogical interaction) as well as **parental involvement**. During the inspection, the inspector

will judge how the provider works in partnership with parents and carers to support children's learning and development, and the promotion of their wellbeing. Inspection checks if settings actively seek, evaluate, and act on the views of parents to determine what needs to be improved, to drive continual improvement. Inspectors evaluate if assessment information on children's development is informed by parents (how and when are parents asked for information about their child's development), and if/ how often staff share a good quality summary of their child's observations with the parent, if staff engages/supports parents in their child's learning (at home), how well staff works with parents to promote children's good attendance.

Child outcomes are assessed internally, through ongoing formative assessment. They aim to help parents, carers and practitioners to recognise children's progress, understand their needs, and plan activities and support. Development reports at age two and before entry to school aim to identify the child's strengths and areas where progress is less than expected. External assessments of child outcomes are based on direct observations (which are carried out during the inspection), surveys taken by inspectors, and settings' policy and record keeping documents are analysed (Ofsted, 2015b; Ofsted, 2015c).

In addition, the Department for Education publishes reports on ECEC participation. Each local council has a duty to make sure there is sufficient childcare provision in the area to enable parents to work, or undertake education and training leading to work. In support of this duty, local councils are required to report annually on how they are meeting their duty to secure sufficient childcare. This report is made available and accessible to parents (for further details, see The Childcare Act, 2006).

2.2.2.4 Language

Public health services for young children (0-5) and their parents

The NHS offers an interpreting service. This includes face to face interpreters in British Sign Language and languages other than English, telephone interpreting in other languages and written translation. In practice, language and the lack of adequate and accessible information and interpretation and translation services have been identified as barriers to access to health care for migrants and refugee families (Renton, Hamblin & Clements, 2016).

The NHS offers health information in languages other than English online. Most pages on the NHS website can be translated, using Google Translate, into more than 90 languages by clicking on a link which can be found on the top of the website page. Translated texts however, are not the same quality as if translated by a human translator, and the quality differs between languages.

Family and parenting support provided through local authorities

Local authorities offer interpretation and translation services which families can access. Some service providers (including Children Centres) have outreach teams which may include bilingual practitioners, community officers or assistants; some providers (e.g. ECEC providers) offer support in home languages from staff with Early Years qualification who work with young children and their families; some offer groups for families with the same language backgrounds, to enable them to facilitate their heritage language and practices; some offer English as Additional Language (EAL) courses for parents with other language backgrounds.

Early childhood education and care (ECEC)

In schools and ECEC provisions, **EAL learning** takes place within the context of the mainstream curriculum, and **schools and ECEC providers** can make additional provision for EAL learners, sometimes with additional specialist funding. Specialist teachers and support staff include EAL teachers and co-coordinators, bilingual teaching assistants, and EAL (or Ethnic Minority Achievement) consultants (NALDIC, 2012). The **Ethnic Minority Achievement Service** (EMAS) supports pupils who have English as an additional language in ECEC centres and schools. EMAS provides advice to providers and parents on how a child can best be supported, carries out assessments and monitors progress, works with other agencies such as Health and Social Services; liaises with education teams to make sure that the needs of children from Minority Ethnic backgrounds are considered. EMAS usually comprises of a team of specialist teachers, teaching assistants, bilingual liaison workers, and home school liaison workers. ECEC providers can refer children to EMAS, and support can be available for two, three, and four-year old children. Health visitors can also refer a child to EMAS. Relatedly, in some areas in England **Travelers Education Services** provide interpretation and translation services. They also offer advice and support to schools, concerning the inclusion of pupils from Traveller families, ways to help traveller parents access and understand education systems, and ways to involve traveller parents in their child's education as, for example, through the Ethnic Minority and Traveller Achievement Service.¹⁷

2.2.2.4 Main challenges

Public Health Services for young children (0-5) and their parents

Since 2015, local authorities in England have had responsibility for the provision of health promotion and protection services for young children, from conception to age 5, provision is delivered through the Healthy Child Programme 0-5. Thus, every local authority now has the ability to shape their Healthy Child Programme to meet local needs (with some elements required by regulations, hence 'mandated'). Yet, local authorities have recently seen significant reductions to the funds available for early intervention services (The Children's Society, NCB, Children & Young People Now, 2015). As a result, some local authorities are struggling to maintain service level. Reductions in public funding mean that non-statutory services need to be reviewed and redesigned to meet increasing cost pressures. Furthermore, differences across regions also exist with regards to mandated universal services - for example variation was found across England as to whether families have access to the mandated universal health visiting service (with London least likely to receive the required number of health visits).

Recently the sector has seen a significant decline in health visitors and school nurses. Yet, the public health nursing workforce is crucial to making the Healthy Child Programme a success. Reductions in the workforce are due to cuts in funding, and the fact that local authorities are re-commissioning services to a range of providers, making it increasingly difficult to track workforce development and carry out effective planning (Fagan, Williams, Fennel, & Russell, 2017)

Local authorities are expected to carry out local needs assessments to identify sub-populations in the community, including refugees and migrants, and set out action required to address their specific needs. Yet, there is limited information on shaping the Healthy Child

¹⁷ See <http://www3.hants.gov.uk/education/ema.htm>

Programme 0-5 so that it meets the specific needs of refugee and migrant children. The National Children's Bureau (NCB) recently conducted a review of the evidence on public health issues affecting young refugee and migrant children aged 0-5 (Renton, Hamblin, & Clements, 2016). It was concluded that refugee and migrant families face barriers to accessing GP services, including confusion around entitlement and registration requirements among families and GP staff. Refugee and migrant women who are pregnant fear large bills, as well as requirements around the provision of documentation. These fears act as barriers to accessing antenatal care, with implications for maternal health and the child's early health and development, including poor mental health which seems to be an issue for refugee and migrant children in particular. Social factors underlying health inequalities affecting *other* groups of children – such as poverty and poor housing – also have a part to play in the relatively poor health outcomes of some refugee and migrant children (*ibid*).

Family and parenting support provided through local authorities

A number of challenges have been identified when it comes to the support provided through local authorities to families. These challenges fell under two distinct categories: those which stem from family characteristics and those which stem from service characteristics. Families are unique and experience diverse and sometimes multiple needs. Although there are a number of support services available to families these services can be fragmented. There is often the dilemma as to whether such services should be offered via universal or targeted provision, and a necessary consideration of high costs for services which are not consistently available for a continuous delivery.

Family challenges

Families have many and varied needs, including help with parenting skills, mental health problems, and severe social isolation. Efficient use of resources requires careful targeting of services to the discrete needs of vulnerable families. In addition, the support provided to families should match the needs of the community. Thus, community development methods are essential to ensure resources address what is needed for parents living in their local areas.

Service challenges

On the other hand, focusing too heavily on community engagement features can lead to fragmentation of early years services, and a lack of a coherent strategy for service delivery. Parent support services do not only have to provide what parents are asking for, but also should deliver according to what we know about effective practice. In response to the risk of fragmentation through service integration, community needs must be addressed with well-evidenced programmes and a range of supplementary programmes which are much welcomed by families; much like the mission was taken on by the (Sure Start) Children's Centre initiative.

This style of initiative is a complex task and involves local consultation, understanding what is already available for young children, and putting together partnerships with appropriate agencies. The challenge is that centres need time to get started, and that a demanding skill-set is required to run a children's centre, including the right combination of community skills, high-level knowledge about young children and parenting, and the ability to work across different management levels and different professions. With low wages, low status of work with young children, and no clear professional ladder to climb, finding skilled staff is difficult.

The (Sure Start) Children's Centre initiative started as a programme targeted to the most deprived areas in England, but the programme expanded rapidly, to offer services to families more widely. Offering children's centre services to everyone in the local areas was perceived as a way of reducing the risk of stigmatisation. Data indicate that services were liked and used by families, including low-income and middle-income families as well. Still, a considerable percentage of families in children's centre areas did not take-up services, and for those the fact that others were engaged in a centre (whilst they were not) may have left them even more isolated. Thus, the issue of hard-to-reach families pertained (Eisenstadt, 2011; Geoff, Hall, Sylva, et al., 2013; Smith, Filed, Smith, et al., 2014). Offering children's centre services to everyone is also costly, and related to an increasingly tight economic climate with financial cuts in funding, centres are being modified or closed by some local authorities. This risks a shift towards a more focused and targeted range of services for parents as well as outreach to homes, thus once again increasing risks of stigmatisation.

Early childhood Education and Care Sector

Whilst the mission of ECEC services in England is to offer good quality ECEC to all children and thus maximize the positive impact of ECEC attendance on child outcomes, *equality* in ECEC remains a challenge. For policy-makers there are challenging decisions to be made regarding targeted versus universal provision. In widening access and offering ECEC free to all children, the increase in subsidies reduces the funds available for ensuring that provisions are of good quality. Yet, research has shown that, in order to help children to catch up with their peers, their quality of care and education has to be high (e.g. Melhuish, Ereky-Stevens, Petrogiannis et al., 2015). Thus, a key consideration is how to ensure high quality provision, in particular for disadvantaged children.

Ensuring quality of the ECEC workforce is an important issue. Staff need to be well prepared for working with young children, especially in the context of disadvantage and cultural and linguistic diversity. Qualifications need to include content relating to those diverse groups, and staff need to be well supported and have access to high-quality professional development. In England, high diversity in training and working conditions is found between staff working in different types of ECEC provision. In addition, structural aspects of ECEC vary across different types of providers, affecting pedagogical practice and levels of process quality. Despite Government commitment to improve the workforce in the Early Years sector, issues around pay, qualification levels and continuing professional development and support remain a challenge in England (Mathers & Ereky-Stevens, 2017).

Another challenge relates to equal access. Outside the free entitlement to ECEC, parents pay the costs of childcare, and the costs are high – in particular for providers offering full-time care (which are mostly profit-making, non-state settings) (see Resa, Ereky-Stevens, Wieduwilt et al., 2016); this relates to issues of segregation. The availability of 'wrap-around-care' in part-time provisions needs to be increased so that ECEC (particularly in state settings) become more accessible to working parents and the split between different populations accessing different type of provision can be reduced. Data further exemplifies how the socio-economic status of families affects the uptake of free entitlements. For example, the Department for Education reported in 2015 that only 58% of 2-year-olds eligible to a funded place in ECEC were actually taking up their free place. Thus, despite the targeted offer of free access, reaching those families most in need remains a challenging issue (Resa et al., 2016).

Summary

This chapter provided a brief overview of the available family and parenting support services for families with young children below primary school age (under 5) in England. It addressed both broader early support services – including early childhood education and care, public health services for young children/families with young children; and finally family and services support for parenting. In doing so it offered an overall description of the services, identified issues of equality, assess, outreach and monitoring of these services; highlighted how language barriers are addressed within these services and delineated some key challenges in all of these services on offer. Whether it is the financial cost, the decision between universal and targeted services, the lack of multi-layered professional skills; or the unique and varied characteristics of the families that these services meant to support, in England there is a plethora of mechanisms in place. An overarching climate of austerity makes decision far more difficult than it was year ago but overall there are systems in place that if well-aligned they can offer a comprehensive all around support to young children and their families.

2.2.3 COUNTRY PROFILE: GERMANY

Hande Erdem, Yvonne Anders

2.2.3.1 Services overall description

In Germany, the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) coordinates parental support at the country level. However, Germany consists of federal states, and legislation at the country level needs to be translated into laws at the level of the federal states. According to SGB-VIII (SGB is German and stands for *Sozialgesetzbuch*, meaning Social Security Code), every family or parent-to-be is entitled to receive some form of family support. The laws of each federal state specify the rights of these support schemes. Naturally, federal legislation and municipal responsibilities have led to important variations between and within federal states with regard to the provided services for family support and their structure, building up an heterogeneous infrastructure of public and private youth welfare services (public, free-charity and private providers).

Yet this heterogeneous infrastructure arises not only from the principle of federalism, but also from Germany's principle of subsidiarity. The principle stipulates that action shall be taken at the lowest level and by the smallest unit possible, thereby leading to a decentralized system in which small providers are being granted high autonomy. The idea behind the principle of subsidiarity is that small units at a low level are better able to react to their respective social environments, including regional particularities (Resa et al., 2016).

Accordingly, Germany provides different intervention and prevention services which are mainly connected through a network, which itself consists of local structures and coordinated support services (Renner & Heimeshoff, 2011). The main institution for developing and implementing prevention and early services is the National Centre on Early Prevention (*Nationales Zentrum Frühe Hilfen, NZFH*). It coordinates the local child and youth welfare services as well as local health services with the goal of improving the support of families (Lengning & Zimmermann, 2009). These services are universal in scope, addressing all families as well as specific target groups.

The most common prevention and intervention services are:

- welcome letters by municipalities;
- visiting parents with new-borns in their homes;
- family midwives;
- antenatal classes;
- parenting courses;
- parent-child-groups/baby and toddler's groups;
- prevention projects addressing pupils;
- professionals supporting families on a voluntary basis;
- counselling services for parents;
- educational support by multi-professional teams (*Erziehungshilfen*) (Sann, 2012; NZFH, 2015).

Besides these genuine prevention services, early health care services and early childhood education and care (ECEC) have become the important players and sector for prevention in early childhood.

Health care

Health care for children and youth, as well as primary health care in general, is paid by public or private health insurances for economically active persons. For unemployed people health care is covered by the social insurance. Each pregnant woman is entitled for regular check-ups at a gynaecologist or a midwife before birth and may receive up to daily support by a midwife for several weeks after birth who also provide breastfeeding support. Children are registered at the general practitioners for children and youth according to the choice of parents made just after birth. General practitioners also provide vaccinations against infectious diseases, in addition there are 7 prevention checks until three years of age and four further check-ups until age 10. These visits include vaccinations, nutritional advice, investigation of the psychological and physical development, hearing examinations, sight examinations and general sensual checks.

ECEC

Since 2013, Germany has implemented the legal right to a (part-time) place in an ECEC setting for all children from the age of one. This policy aims at giving educational opportunities to all children as early as possible. At the same time, provisions of ECEC services have been extended heavily. Likewise, the number of children (0-3 years) participating in ECEC has increased (2008: 17.6 %, 2015: 32.9 %) (Plewka & Scholz, 2016, p. 2). Although it is not compulsory to attend institutional ECEC, approximately 95 % of the children between three and six years are enrolled in ECEC (Autorengruppe Bildungsberichterstattung, 2016). Since in 2015, just 32.9 % of the under 3 years old participated in ECEC, children in Germany are so called late users of ECEC. Strikingly, children with immigration backgrounds in general are less likely to be enrolled in ECEC when compared to children without immigration background (e.g., 22 % of the under 3 years as compared to 38 % in 2005; 90 % of the over 3-years old as compared to 97 % in 2015) (Bildungsbericht, 2016, p. 10, p. 58).

At the municipal (local) level, Germany has implemented family centres (*Familienzentren*). These centres provide different kinds of services and often combine counselling services for parents and families with ECEC. Based on an approach following current needs, the services are child-oriented and at the same time, support families in various ways (Plewka & Scholz, 2016). These family centres embrace a universal approach by being open to all parents and all children. Family centres serve the needs of immigrant and educationally deprived families especially because: a) they are located in the neighbourhoods of these families, very close-by to their homes, b) they speak the language of these families, e.g., they have a hands-on approach, they employ social workers having a migration background themselves, often sharing the same religion (e.g., Islam), c) they provide for things the family itself cannot: help with homework or organising activities. Each family centre has the flexibility to develop its own profile according to the needs of the respective local community. To promote participation on-site and to create strong local networks, family centres are mainly located in socially deprived areas. Since they involve all families, and in particular the disadvantaged ones, they serve as sites for prevention (Eurochild, 2012; Plewka & Scholz, 2016).

All programmes increasingly provide target groups with information on further services, as they are themselves not able to cover the whole range of services needed (e.g., through

leaflets presenting the service and providing the relevant contact information). Furthermore, doctors, clinics and preschools are being involved to reach families in need of support (e.g., information events in preschools, leaflets in doctors' office and clinics).

Main goals of the services

The overall objective of the services is to enhance (equity) equality for all children and families in Germany, irrespective of their social and cultural background. While the specific objectives and strategies of the services and programmes vary to some extent, aims and strategies of programmes for the same target group (e.g., age of child, targeting disadvantaged families) often share certain similarities. The offers for parents-to-be include counselling for legal issues, partnership conflicts and family support services, courses to promote fitness, relaxation and healthy nutrition, as well as provisions to connect with other parents-to-be, to prepare for birth and the first months of parenthood.

Early intervention services aim at identifying risks for the child's wellbeing at an early stage and providing support within the families. Family centres in this context serve as a paradigm, as they aim at strengthening parenting skills and balancing family and work life at an early stage (Eurochild, 2012).

In general, particularly the programmes that go beyond children's first year of life also offer parental education, seeking to teach parents how to stimulate child development, although mainly considering children's general cognitive development and (German) language acquisition. Due to this focus, they often miss out on pre-academic areas such as mathematics or science and native language acquisition. Programmes for the subsequent phases shift their focus to parenting practices (e.g., setting limits and stipulating rules, teaching reinforcement and appropriate punishment techniques, consistency, approval and praise of children's achievements). Also, they consider how to support children's cognitive and social skills (e.g., how to share, how to interact with the environment; namely peers, siblings and adults). With increasing age of the children, programmes tend to focus more on the prevention and reduction of specific problematic behaviour and difficulties of children (e.g., aggression, antisocial behaviour, delinquencies, depression, smoking, drug/alcohol abuse, school failure, learning disorders). The idea of connecting and fostering the exchange between families in similar living situations is implicitly or explicitly present in most of the programmes. Most programmes are multi-faceted and try to achieve multiple goals with various strategies and methods.

Key actors

As it was previously stated, the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) coordinates the parental support at the state level. As part of the governmental programme, the National Centre on Early Prevention (NZFH) was established in 2007 to provide early prevention support services for parents and their children, carrying out various pilot projects in Germany. For these projects, children and youth welfare offices are the most important partners to cooperate with, gaining access to high-risk families as well as establishing sustainable relationships. Further important actors for cooperation are maternity clinics and doctors in private practice. Additionally, family midwives and pregnancy counselling centres also play a crucial role as cooperation partners (Renner & Heimeshoff, 2011).

In line with section 81 SGB VIII, the Child and Youth Welfare Authorities are furthermore obliged to cooperate with other institutions, to jointly work for improving the living situation of young people and their parents. These other institutions are, for example, schools, institutions for education and training, the public health service, the unemployment office, other social services and the police (Galm & Derr, 2011).

Family centres are a central hub in the sense that they bring together different actors. Their network consists of further partners such as primary schools in the neighbourhood, local family counselling agencies, child minders and other child and family related services provided by churches, family education centres, and independent associations. In addition, they selectively cooperate with other institutions such as the local library and sport clubs (Eurochild, 2012).

Besides small, non-governmental and non-profit providers, churches are important providers of child and youth welfare in Germany. The principle of subsidiarity ensures that municipalities take action only if churches or other providers do not or cannot. Especially in the Western part of Germany, churches provide a considerable proportion of services. In general, the influence of churches on pedagogy traditionally has been rather big in Germany (Resa et al., 2016). The social arms of the two major churches in Germany, namely the German Caritas Association and the Service Agency of the Protestant Church, are autonomously responsible to cater for social services. The charitable association of the Catholic Church for instance, comprises around 600 small associations at local levels throughout Germany, among which there are ECEC provisions. Regarding governmental funding of services, the amount is often in accordance to the socio-demographic structure of the community as well. This is due to the German government's attempt to enhance the access of services to those most in need, meaning that deprived communities are eligible to more funding (Becker, 2008).

2.2.3.2 Equality issues (regarding ISOTIS target groups)

Germany's attention to early prevention and intervention services is strongly driven by the aim to reduce inequalities, as can be seen in the wide range of provisions such as ECEC based support, family centres and family midwives, amongst others. The family centres, for instance, allow to identify and tackle educational and language deficits especially among immigrant children. In order to do so comprehensively, not only children's weaknesses but also their strengths are identified at an early stage. In this line, their parents receive counselling for training, healthcare, education etc. as soon and early as possible (Eurochild, 2012). Yet, parents' acceptance of prevention and intervention services, such as the support by a family midwife, depends on their social class, status and educational level. For example, Turkish families with strong family ties tend to care for their children within the family circle, rather than accepting support from outside. The Federal Child Protection Act has aimed to increase the number of families allowing for support by midwives following the birth of the child (Galm & Derr, 2011).

In Germany, funding for ECEC is often linked to the socio-demographic structure of the community or neighbourhood. By this approach, the German government tries to enhance the access of services to those most in need. In some federal states and regions, such as Hamburg and Berlin, voucher systems have been introduced (so-called *Kitagutscheine*). Instead of the

municipality organising ECEC centrally, parents are granted vouchers which they hand in in their prioritised child care centre. The centre itself receives money in accordance to the number of vouchers at hand. This system is said to be more flexible to react to the precise needs on-site. In many cases, the vouchers' worth is determined in accordance with the respective centre's social environment and clientele (e.g., more money is spent in low-income neighbourhoods) (Edelmann, 2011; Diskowski, 2016). The German government believes this system to increase competition and thereby quality.

Furthermore, in Germany many provisions exist for families and parents with low incomes:

- 170 EUR *Kinderzuschlag* is paid monthly for max. 36 month to parents with low income for each child. It requires drawing unemployment benefits;
- pregnant women are equipped with essentials for their new-born (*Erstaussattung*: e.g., pushchair, diapers, clothing for the baby etc.);
- non-cash benefits (in the context of *Teilhabe- und Bildungspaket*) are given to parents for their children so that these can adequately participate in education (e.g., vouchers covering school material, books, school meals, train tickets, and school activities such as excursions);
- *Wohngeld* subsidises rent payments;
- and: parents with low incomes either pay nothing or a reduced fee for enrolling their child in a child care centre (Bundesministerium für Familie, Senioren, Frauen und Jugend, 2017).

Main Strategies

Considering the NZFH's (National Centre on Early Prevention) pilot projects in Germany, it has to be said that the Centre applied several strategies to maximise its outreach, trying to reach families avoiding stigmatisation. The projects contained trust-building measures with repeated invitations, working confidentiality. Also, the support services were offered for free and rewards such as motivational presents for families were used during the processes. Parents for instance received videos and photos of their children participating in the projects. In addition, networks played an important role, for example cooperation with counselling services, children and youth welfare offices, support services, gynaecologists in private practice and job centres. Informational and advertising materials as well as positive media coverage also gained importance (Renner & Heimeshof, 2011).

Furthermore, in the context of the National Initiative on Prevention and Early Intervention, great importance has been given to professionalisation by means of (Plewka & Scholz, 2016, pp.5-6):

- Competences profiles: They are developed for early prevention-related professional groups to provide standards for vocational training: family midwives (*Familienhebammen*), family health and child nurses (*Familien-Gesundheits- und KinderkrankenpflegerInnen*), network coordinators (*Netzwerkkordinatoren*);
- Promotion of volunteering in the field of prevention;
- Networks at the local level: coordinating teams (*Landeskoordinierungsstellen*), responsible for quality management issues, offering a platform for exchange;

- Vocational training in the ECEC sector: This is developed and provided for ECEC professionals.

2.2.3.2.1 Conditions of access

Primary prevention activities such as the welcome letter, the information packets at birth, the check-up programme for children and the midwives' home visits, are funded by the public health care system and available to all families (Benz & Sidor, 2013). The secondary prevention activities (e.g. groups for parents with infants and toddlers) are mainly made available by public providers and the private sector.

Public providers' programmes are funded by the youth welfare system. Yet, several programmes within the private sector charge fees, with families in need of paying themselves for participating in courses.

2.2.3.2.2 Coverage/outreach

I. Income level of parents: cash-services (e.g., subsidizing of ECEC and educational costs; see above) as well as specific programmes for the target group (e.g., Opstapje, Eltern-AG, KIFA) are provided.

II. Ethnicity: The term ethnicity is rarely used in political or scientific debates in Germany.

III. Immigrant status: The *Königsteiner Schlüssel* serves to distribute the funding for social support, programmes (e.g., *Stadtteilmütter*, KIFA, Acilim, *Eltern-AG*) and refugee/asylum services between federal states. It is based on regional socioeconomic statistics.

VI. First spoken language: Support of the first spoken language is mostly lacking in the different approaches and programmes. Some programmes exist (e.g. *Rucksack KiTa*); sometimes language courses are offered in schools or culture centers of migrant communities (e.g., Turkish, Portuguese), bilingual ECEC centres; ECEC centres with approaches of multicultural education, using, appreciating and further developing children's first languages.

Looking at the family centres in Germany, it can be seen that they mainly implement support services in childcare centres, since it is rather easy to reach children and families and gain their trust for the family centres' work. As these family centres are highly intertwined with the existing family support services of the local infrastructure, they provide low-threshold services for children and families. They follow an integrated approach: next to offering learning activities for parents, they also cooperate with the local family counselling agencies and other professionals, for instance in the realm of health care. These professionals offer regular consultation hours and information sessions in the family centres. What is more, parents and families take an active part in the planning and realisation process of the projects and activities they participate in. Families considered being hard to reach are mainly visited at home by the centre's staff to identify the particular needs of the individuals and to really grasp their living environment (Eurochild, 2012). Moreover, Germany holds specific residential institutions for young single parents with small children. These institutions enable them to take care of their child within a protected framework and in a further step, to prepare for an independent care and parenting (Galm & Derr, 2011).

Concluding results based on NTZF, early prevention pilot projects, mainly oriented towards families' living environment, showed that one-quarter of the families contacted

preferred to not make use of a support service. They also showed that besides identifying families who need support, it is crucial to motivate families to attend support services (Renner & Heimeshof, 2011).

2.2.3.3 Monitoring

To our knowledge, there is neither a nationally coordinated nor a strategic monitoring system in Germany. Some federal states have their own monitoring systems (e.g., Lower Saxony) and there are some statistics on national level providing first answers to the provision and usage of services.

There are some further attempts to document the provision and usage of family support in certain regions. Some surveys and reviews on family services do therefore exist (in German “Bestandsaufnahmen”; Lösel, 2006; Bestandsaufnahmen of the NZFH [Nationales Zentrum Frühe Hilfen]), including reviews/meta-analyses on the effects of early intervention programs in Germany (e.g., Taubner et al., 2013a, b).

2.2.3.4 Language

As it was previously stated, language support programmes considering mother tongues are mostly lacking in Germany. Yet, some schools and some cultural centres provide some language courses and besides, some ECEC centres do have bilingual education, taking mother tongues into account.

2.2.3.5 Main challenges

Most of the programmes are local, being neither well documented nor evaluated systematically. As Germany consists of 16 different federal states, cooperation and networking are rather challenging, both on the institutional as well as on the practical level. Further, the outreach of families who need support is problematic. Most programs are supposed to be made for target groups (low SES, migrants) but the strategies to reach them are often not successful (Lösel, 2006).

Another issue is to find a balance between the different needs of different target groups that need to be addressed. Low SES families, Turkish families, Arabic families are diverse regarding their culture, language, integration level in the educational system. For example, Germany has no systematic L1 support program, which is successfully nationwide implemented and evaluated. Further, the using of ICT in family support programs doesn't play a role yet, even though ICT is for most people common in everyday life.

2.2.4 COUNTRY PROFILE: NETHERLANDS

Ryanne Francot, Martine Broekhuizen, Paul Leseman

2.2.4.1 Services overall description

The overall structure of the system of early childhood services and family support in the Netherlands can be described along vertical and horizontal axes (Leseman & de Winter, 2013). Vertically, the system can be divided in two phases: the preschool phase (0–4 years) and the primary school phase (4–12), including two years of kindergarten (4–6). The horizontal axis can be divided by sectors governed by different national ministries and local authorities. These sectors, which operate under different regulations and legislation, are financed in different ways. Below we will outline the A) youth health care sector and B) youth care sector (including mental health care and justice sector involvement) as two horizontal sectors. Next, in terms of (early) education and care we will describe the vertical C) preschool phase (0–4) and D) primary school phase (4–6).

Four ministries are responsible for various aspects concerning youth in the Netherlands (Van Riel & Van der Kooij, 2016):

- Ministry of Health, Welfare and Sport: Overall health and youth policy and more specialised services for families and children.
- Ministry of Security and Justice: Juvenile justice policy and related institutions.
- Ministry of Education, Culture and Science: All educational matters, including preschools and child day-care with educational programmes.
- Ministry of Social Affairs and Employment: Labour related measures, including the Child Care Act for child day-care centres and the after-school care sector.

Between the four different ministries, a regular interdepartmental consultation takes place.

Most family support, youth (health) care and early education services (preschools, host families, and child day-care programmes with specific educational programmes) are run by public organisations in the sense that subsidies are public and that providers are not-for-profit foundations. Charities play only a minor role in some localities. In the sector family support and youth care many organisations have roots in former charities connected to the main religious pillars, but subsequent reorganisations and mergers have reduced the role of charities and funding is public nowadays. The child day-care and after-school care sector is a hybrid sector with public and private providers. About half of the capacity is provided by private for-profit organisations, the other half by public organisations or by non-profit private organisations (foundations with a social mission) (Van Riel & Van der Kooij, 2016).

YOUTH HEALTH CARE SECTOR (0-6)

Maternity care [Kraamzorg consists of 40–50 hours of home care provided for mothers and babies by licensed maternity nurses in the first eight days following birth (Leseman & de Winter, 2013). The service includes supporting and educating the mother, caring for the new-born, modelling care behaviour, performing light household chores, caring for other young children in the family, and monitoring the baby's and mother's health. A national protocol in 2006 defined maternity nurses' tasks, set out health and well-being indicators for mother and baby, and put in place care quality regulation. Maternity nurses have close contact with midwives and general practitioners (GP). Maternity care is provided by for-profit and by semiprivate not-for-profit

organisations and is part of the standard insurance policy that is obligatory for all citizens in the Netherlands.

Baby and toddler health centres [Consultatiebureaus] are the backbone of the public health care system for 0–4-year-olds (Leseman & de Winter, 2013). They are located in neighbourhoods, are easily reachable, and visits are free of charge. Although these centres form a nationwide system of public youth health care, they are operated by Municipal Health Care authorities [GGD] or by the regional home care organisation Homecare [Thuiszorg] in some regions. Homecare came into being through a series of mergers involving several formerly independent municipal welfare services and charities, and provides a broad range of services.

The centres are notified of new-born children directly from the municipal population register. Parents are contacted by mail or telephone to organise each visit. Although attendance is voluntary, most parents respond to the call and over 96% attend most scheduled visits in the first year, with attendance between 90% and 95% in following years. The present scheme consists of 8 visits to the centre in the first year, then visits at 14 and 18 months and then each year until the final visit shortly before the fourth birthday (at the time of introduction to universal kindergarten, which is integrated in primary school). During these visits, physical features, gross and fine motor movement, cognitive-, language-, social-emotional-, and behavioural development are evaluated as the child develops over the years. Results are noted in the “growth booklet” that all parents receive at the first visit and also in a digital child record. Most examinations are carried out by (medical) nurses, but there is also a brief consultation with a paediatrician on every second visit. Parents are advised to contact the GP if serious deviations from age-norms are detected, or are referred directly to a hospital or institute for child mental health care.

Baby and toddler health centres in most municipalities also have a *home-visiting programme consisting of two home visits*. These take place within the first two weeks of the child’s birth to educate parents about health care, hygiene and nurturing, and to speak to them about the first examination at the centre. The child is vaccinated in the first and second year and again at age four (against almost all childhood diseases), although vaccination can be refused on, for example, religious grounds. Educating parents about childrearing is now part of the centres’ work, as is screening families for possible child abuse and maltreatment.

YOUTH CARE SECTOR (0–18 years)

Since 2015, all Dutch municipalities are responsible for the whole range of care for children from birth to 18 years of age and families in need of support and assistance (Netherlands Youth Institute, 2017). The municipalities now manage a wide range of services for children and families, ranging from universal and preventive services to specialised - both voluntary and compulsory - care for children (Van Riel & Van der Kooij, 2016). Before 2015, the youth care system was the responsibility of the country’s twelve provinces.

Since the decentralized responsibilities in 2015, many municipalities have established multidisciplinary teams in neighbourhoods (in Dutch ‘Wijkteams’) to provide comprehensive care and outreach (children, family or citizens) within the neighbourhoods. These teams, which are now active in almost 70% of all municipalities, act as primary youth care providers or generalist care providers for all citizens (Netherlands Youth Institute, 2017). The teams differ per municipality, but in general they consist of health care workers, social workers, parenting

support workers, (school) psychologists and others active in the care field. They are the linking pin between the preventive and universal services, on the one hand, and specialised care, on the other hand.

The youth care sector is involved with “special needs” of children and their families (psychosocial and behavioural problems and disabilities for which remedial and therapeutic services are offered) such as *special education* (Leseman & de Winter, 2013). It also has a strong preventive orientation in that it focuses on the contexts through which children may develop serious problems as they grow up, particularly the family context. Youth care service provision is diverse and is layered according to the severity of problems presented. Highly accessible low-threshold services (e.g., *Centres for Youth and Family*) have a demand orientation to which parents can apply voluntarily for advice or help, but there is also non-voluntary residential care in children’s homes for very serious cases of child abuse and neglect. *Centres for Youth and Family* often have a baby and toddler health care centre integrated.

Preventive approaches to youth care, youth health care, and (pre)school educational support have culminated in the concept of *family support*, which integrates views on how to deal with diverse problems and social contexts related to child development and childrearing. Some specific parenting support programmes were adopted from abroad, such as Home Start from the United Kingdom. Video home training and demonstrations by home visitors of how to play and interact with young children are also quite common. Some programmes target socioeconomically disadvantaged groups and focus on improving early education in the family. Numerous small- and larger-scale activities and services recognised as “family support” augment these specific parenting and family support programmes.

Several studies found great diversity in activities offered across municipalities (Leseman & de Winter, 2013). For instance, up to forty organisationally different (though sometimes overlapping) family support services were counted in some municipalities. These included: front-desk offices offering information, advice, low-intensity guidance and home training; pedagogical advisory services connected to baby and toddler health centres; informal parent groups connected to playgroups or preschools; play-advisory centres and low-cost toy rental shops; parental education courses on specific subjects (such as for families with adopted children or with children suffering from asthma) or general childrearing issues; psycho-diagnostic services; intensive home training for children with behavioural problems; information desks to support parents’ decisions about primary school choice; and educational home-based programmes.

Preschool phase (0–4)

Early childhood education and care (ECEC) currently reflects two distinct traditions in the Netherlands:

- A *care tradition* to support working parents in caring for their children;
- An *education tradition* aiming to stimulate children’s social and cognitive development and prepare them for formal education in primary school.

The description below of the two types of preschool centre-based service is still relevant, but it should be kept in mind that boundaries are fading, and the child day-care centres increasingly take over the educational role of preschools and playgroups with concomitant subsidies.

Day-care centres (0–4 years)

The primary goal of day-care is to provide care for 0–4-year-old children whose parents are working or in full-time education. There are both community day-care centres operated by not-for-profit organisations and private day-care centres that work for profit. At first glance, practice and quality of care does not differ systematically between the different forms of day care (Leseman & de Winter, 2013). Full-time care is very rare with children spending on average between 16 and 24 hours per week in the centre. At least 32% of 0–4-year-olds attended a day-care centre in 2015 (Statistics Netherlands, 2016). With the exception of babies, most children attending day-care centres follow a fixed schedule of eating, drinking, (unguided) play, gross motor activities, and afternoon naps with the whole group. The role of more explicit educational teacher-guided or teacher-directed activities in the schedule is not clear and varies between centres.

Host families / non-familial home-based care (0–4 and 4–12 years)

Officially licensed host families (also referred to as “childminding services” or “non-familial home-based care”) serve the same population of 0–4-year-olds. These families are usually members of large, regionally or even nationally operating not-for-profit organisations that are responsible for selecting host families, training host parents, providing continuing support and supervision, establishing complaint procedures and placing children in families. About 6.8% of the 0–4-year-old children and 3.1% of those aged 4–12 were cared for by officially licensed host families in 2015 (Statistics Netherlands, 2016). Host families care for up to four children per day, with a maximum of six children (Rijksoverheid, 2012) .

Playgroups/preschools (2–4 years)

The pre-primary school component in the educational tradition consists of playgroups and preschools for children between two and four years. The Dutch word is “peuterspeelzaal”, meaning “playgroup for toddlers”. Playgroups and preschools are increasingly identified as local education policy priorities because of their low threshold, relatively low costs for parents and strong connections with local neighbourhoods. Extra efforts have been made to attract minority and low-SES children, with apparent success, particularly in inner city areas. A recent trend has seen the transformation of playgroups to preschools that offer a targeted programme, starting between ages two and three and forming a continuous education trajectory through to kindergarten. Attendance at these settings is typically four mornings (or afternoons) per week, with an ensured teacher–child ratio of 1:8. Municipalities are obliged to offer targeted ECEC programmes to all children between 2 and 5 years who run the risk of a language deficiency or being educationally disadvantaged at a preschool or day care institution. Municipalities are furthermore obliged to make agreements with the relevant institutions/organisations on reaching the target group, identifying the target group and regulating inflow in preschool education programmes.

Almost all playgroups and preschools promote informal communication with parents, not only through daily contacts, but also within “coffee-break meetings” for parents which serve as informal self-help groups on childrearing-related issues. These meetings are recognized as important settings for reaching out to parents to secure wider family support where necessary. According to statistics from 2013, about 37% of 2-4-year olds attend a playgroup or preschool centre (Statistics Netherlands, 2013), typically, for two or four mornings (or afternoons) of 2½-3

hours per week, 42 weeks a year. In general, they are not part of the child day-care system because of their opening hours (09:00–11:30 or 13:30–15:00), although there are some organisations which integrate services.

Primary school phase (4–6)

Kindergarten departments in primary school

Primary schools (encompassing two years of universal kindergartens) cater for children of 4–12 years. Teaching in reading, writing, and mathematics usually does not start before grade 1 (age 6). Primary school is compulsory from age 5, but the Primary Education Act 1985 allows parents to send their child to primary school directly after their fourth birthday without costs: over 95% opt to do so (Leseman & de Winter, 2013).

After-school care (4–12 years)

Children going to school does not necessarily make things easier for working parents in the Netherlands, school opening hours (from 08:30 or 8:45 to 15:00 or 15:15) are not adapted to parents' working hours. Recent statistics show that about 22% of 4–12-year-olds were in out-of-school, centre-based care in 2016 (Statistics Netherlands, 2016).

2.2.4.2 Equality issues (regarding ISOTIS target groups)

2.2.4.2.1 Differential access to services

The described services are either universal (Maternity care; Baby and toddler health centres; Centres for Youth and Family; Day-care centres, after-school care, and non-familial home-based care; Primary school) or quasi-universal (Preventive approaches to youth care, youth health care and preschool educational support; Playgroups/preschools). Nevertheless, there are issues regarding equality in the use of services.

For **playgroups/preschools**, targeted outreach policies and income-dependent subsidies favour a focus on disadvantaged groups, leading to segregated use in practice. Playgroups/preschools are in principle accessible to everyone, (also those that work with a targeted compensatory education programme), although waiting lists sometimes develop. In practice, however, use is socially selective in two ways. Parents who work for a substantial part of the week have to use a child day-care centre because of the limited opening hours. In modern society in the Netherlands, this tends to affect higher-educated parents, who are underrepresented amongst playgroup/preschool users. On the other hand, very low socioeconomic status (SES) families and, particularly, immigrant families are also underrepresented in playgroups/preschools because:

- They charge a small fee (which in most cases is income-dependent, but can still be a threshold for low SES families);
- The free, non-authoritarian pedagogical climate does not match the parents' childrearing beliefs and values;
- Out-of-home care provided by strangers is a cultural taboo;
- Educational potential (valued as such) is not recognized in the play-dominated curriculum.

In general, **day-care centres and after-school care** are a universal service, and the

income-dependent tax reduction was quite substantial in past years, allowing many parents from lower-income groups to use day-care. However, major cuts after 2012 have led to lower-income groups using less hours of day-care (Roeters & Bucx, 2016). Recent statistics show that socioeconomically disadvantaged children go less often to **day-care centres and after-school care** than children from families with average or higher incomes. In very low-income families (family income below 130% of the national poverty level) only 9% of the total number of children went to day-care and 13% went to after-school care. Statistics from 2013 show that 38 percent of the young children (2-3 year olds) from very low-income families do not attend any form of institutional care, compared to 8 percent of the young children from parents with the highest income (Statistics Netherlands, 2013).

For using **host families**, parents can also get an income-dependent tax reduction. In general, host families are a little bit cheaper than day-care centres.

2.2.4.2.2 Targeted Programmes

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

The ministry of Education, Culture and Science manages the educational disadvantages policy by the so-called ‘weights regulation’ (‘gewichtenregeling’). According to this official regulation, a pupil can be regarded as ‘disadvantaged’ (having a ‘pupil-weight’) when his/her parents are (very) low educated. Many of the parenting and education programmes are targeted at these children (Statistics Netherlands, 2017). Half of the ‘disadvantaged’ children come from non-Western immigrant families, with the Turkish and Moroccan immigrants as biggest groups. Besides working with the ‘student-weights’ (see above) municipalities with significant representation of disadvantaged groups have the liberty to use different criteria for defining target groups and many have done so in the past years. Usually non-Dutch home language and non-Western immigration background are added (and recently also refugee status), leading to larger groups marked as disadvantaged with no decrease in the size of the target population as has been found for the official national criterion based on the education level of parents only. The issue of definition is heavily contested between the national government and municipalities.

Families are referred to the parenting- or educational programmes by local Baby and Toddler Health Centres, Centres for Youth and Families, teachers or other local support systems. Municipalities receive funding from the government to offer targeted home-based and centre-based programmes for these disadvantaged groups. The amount of funding is based on the number of children that meet the weighing regulation per school/municipality.

Services oriented to reducing inequalities currently being implemented widely can be divided into *home-based* and *centre-based programmes*. The first of a series of home-based programmes is a Dutch adaptation of a well-known Israeli Home Instruction Programme for Preschool Youngsters (HIPPY) that became available in 1987 (Leseman & de Winter, 2013). This two-year programme “Step up” for 4–6-year-olds and their mothers is highly structured and

requires mothers to work with their child for about half an hour each day on perceptual discrimination tasks, language exercises, picture books, logical-mathematical concepts and cognitive problem-solving tasks. Most home-based programmes take the ethnicity and language of the target groups into account by several actions:

- a) The professional working with the parents has the same ethnic background and speaks the same language as the parents (especially the programmes including home visits).
- b) The provided written information (instructions, books, leaflets) for the parents and the provided storybooks or e-books for the families are available in multiple languages.
- c) Families are encouraged to use their own language while interacting with the children.

Despite apparent success, home-based programmes have never been employed with more than 10,000 families, a small percentage of those eligible. Recent policy emphasis has shifted towards centre-based models, that are occasionally combined with home-based programmes. New home-based programmes to align with centre-based programmes have been developed (e.g., VVE Thuis [Preschool Education at Home]) and are currently implemented.

The ministries of welfare and education jointly initiated the development, testing and evaluation of two centre-based education programmes for 3–6-year-old disadvantaged children in 1995 (Leseman & de Winter, 2013). One was a Dutch adaptation of the High/Scope curriculum (called Kaleidoscoop [Kaleidoscope]) and the other, called Piramide [Pyramid], was an adaptation of the Success for All approach developed by Slavin and Madden (1999). Several other curricula have been developed and introduced over the years. The number of targeted centre-based compensation programmes has steadily increased nationwide since 2000 and in middle-sized and big cities target groups are reported to be reached by 80 to 90% (Leseman & de Winter, 2013).

The centre-based approach for targeted compensatory education has received much government support. Ambitious targets have been set: by the end of 2010, for example, nearly 100% of eligible children should have been enrolled in an officially recognized preschool education programme (Leseman & de Winter, 2013). This target has not yet been fully reached, but especially in bigger municipalities rates are reported of 80 to 90%, but exact, nationally representative figures are lacking. While current attendance is reported as about 13% of all 3–4-year-olds, which matches quite closely the 15% of eligible children defined as disadvantaged by national and local policy, early attendance before age four is country-wide still well below the target due to less successful outreach in smaller cities and rural areas.

The preschools working with a targeted compensatory education programmes in preschools for 2-4 year-olds are often located in areas where there is a larger proportion of socioeconomically, culturally and linguistically disadvantaged children (e.g., certain neighbourhoods in large cities) (Leseman, Mulder, Verhagen, Broekhuizen, Van Schaik, & Slot, 2017). Some preschool centres, but also day-care centres, have an active policy of creating a diverse staff, with for example Arabic or Turkish speaking teachers. However, this is not regulated on any level. Local policy is influential here.

2.2.4.3 Monitoring

Since the institutional framework places the responsibility of policies against poverty and indebtedness in the hands of municipalities, an evaluation of the effectiveness of their specific tailor-made measures does not take place at the national level. Moreover, since they also shape

and implement policies according to their own local situation and capabilities, there are many differences between municipalities, which makes a central evaluation difficult. In specific cases or upon (parliamentary) request, (comparative) inquiries may be conducted with regard to local impact, needs or dilemmas.

Maternity care is regularly monitored by the health insurance companies to check whether the maternity care organisations fulfil their responsibilities. The Inspection for Healthcare (commissioned by the Ministry of Health, Welfare and Sports) supervises the quality and safety of maternity care by regular inspections of all providers (Inspection for Healthcare, 2014). They look at the communication between maternity care and other health organisations and within the organisation itself, training of professionals, storage of data of families, if and how often they visit families, the amount of information on families and how the exchange of information is handled.

Baby and toddler health centres are monitored by the Municipal Health Centres [GGD] and the national Inspectorate for Health Care. The municipal and regional health authorities keep track of attendance rates and vaccination rates. A national organisation, the Netherlands Centre for Youth Health Care (NCJ), monitors trends on a national scale and acts as a centre of expertise. The Inspectorate for Health Care reacts upon reported incidents.

Home-based programmes are reviewed (but not evaluated) by the Netherlands Youth Institute (Nederlands Jeugd instituut, NJI), the Dutch national institute for compiling, verifying, and disseminating knowledge on children and youth matters. An independent committee of the NJI, conducts a 'desk-review' and evaluates based on available documentation whether all aspects of the intervention meet the required conditions. If so, the intervention is recognized and included in their database. There are several levels of recognition, going from 'well-supported' to 'strong indications for effectivity'. To get the label of 'effectivity', a RCT or multiple quasi-experimental studies on the intervention have to be conducted. The recognition of the committee is valid for 5 years, hereafter a new evaluation has to take place.

Centre-based provisions (such as playgroups/preschools and day-care centres) are monitored by the Municipal health services, based on annual reports regarding safety and health measures and regarding statutory structural quality regulations (group size, staff-to-children ratio, educational level of staff). Upon indication or reported incidents, the health authority can pay a visit. Centre-based provisions with an education programme which receive subsidy for working with disadvantaged children are also monitored by the national Inspectorate of Education, as are the preschools and primary schools.

2.2.4.4 Language

The **baby and toddler health centres** examine and evaluate many aspects of the child's development, including language acquisition and development (Bohenn & Janssen, 2006). The centres measure, follow, and evaluate the language development of the child and give information, advice, and instructions to the parents if needed. It is their responsibility to identify possible language delays and to take action if needed.

During the first visit of the centre the professionals collect information about the language background of the family, which languages the child will learn, and whether the Dutch language is sufficiently present in the home environment. During the home-visits the professionals will evaluate the home language environment (e.g. interactions between parents and child, number of books etc.). After the child is two years old the language development will be examined, and

parents will fill in questionnaires (available in multiple languages). Until the final visit, the language development of the child will be monitored.

When a child is raised bilingual, the advice from baby and toddler health centres to parents is to use their own mother language. The idea is that a good and rich language foundation, regardless which language, will help the child to learn a second language. If the parents do not offer a rich language environment, especially in Dutch, or if the centre has the idea that the child may develop a language delay due to other factors (e.g., educational level of the parents), the baby and toddler health centres advise the parents to go to **a preschool or day-care centre with a targeted compensatory programme** or to get support from a **family support programme**, such as Pyramide, Kaleidoscoop or OpStap. All centre-based services but especially the preschools with a targeted programme, focus on the language development of the child to stimulate the Dutch language development before the child enters primary school. As stated before, preschool is universal, and every child can go to a preschool, but a child who has a referral from the baby and toddler health centres has priority and can attend a preschool for four instead of two half-days.

2.2.4.4 Main challenges

Baby and toddler health centres

The Netherlands used to have the lowest infant and childhood mortality and morbidity rates in the world (Leseman & de Winter, 2013). Experts have little doubt that the well-organized countrywide public youth health care system was responsible, but the picture has changed in the past two decades. Mohangoo and colleagues (2008) reported an increase in perinatal deaths over recent decades. Causes are not fully understood, but one factor might be the increased cultural diversity. Nonindigenous communities are reported to adhere less well to the recommendations from baby and toddler health centres and to have less access to information about pre- and postnatal health care. Parents in these communities are also more likely to miss periodic health examinations for their children and to never contact the baby and toddler health centre at all. The fact that the public youth health care system services have been steadily reduced because of budget cuts and that the frequency of child examinations in baby and toddler health centres has decreased over the years, which may have led to more undetected health-, developmental-, and family problems, may also be significant.

Family support services

Current models of (integrated) family support services, such as the Centre for Youth and Family, run the risk of being less accessible for disadvantaged groups. Whereas participation of the health care sector gives stability to the system and, due to high attendance rates of the baby and toddler services, helps to lower the thresholds of the Centres, there is a lack of adaptation to disadvantaged families. For example, much work goes via complex websites in Dutch in some Centres, and outreaching activities such as home visits, low threshold parent discussion groups, and the use of paraprofessionals of the same community as intermediaries have been reduced or have disappeared altogether.

Child day-care and preschool education

There is a risk, due to constant movement in this sector, that high quality services for disadvantaged groups, like the target groups of ISOTIS, which are now mainly provided by non-

profit (mainly public) organisations will be taken over by private for-profit day-care providers. This is currently already happening under the pretext of progressive universalism in integrated services, but the market dynamics in the background can easily lead to reduced access and use, and reduced quality for disadvantaged groups, limiting the potential beneficial effects of the centre-based services for these children. At the same time, awareness has grown that keeping to a strict targeted policy, as used to be operative in the past years, leads to segregated provisions for distinct groups. A good question (for ISOTIS) is how bad it is to have – at least temporary – segregated provisions as a strategy to overcome gaps and to support emancipation of disadvantaged groups. A challenge is to design regulations and to create integrated services that favour access and quality for disadvantaged groups, while still being universal or while developing towards a universal system.

The quality and effectiveness of centre-based care is still limited, although especially in non-profit public providers with a social mission good results have been found with beneficial effects on children (Slot, Leseman, Verhagen & Mulder, 2015; Leseman et al., 2017). Traditional approaches to increase quality and effectiveness have limited results and an organisation-based approach to professional development and quality improvement is a main challenge for the near future.

After-school care

The current socially selective use of after-school programmes by more privileged families is suspected to widen the education gap between privileged and disadvantaged groups. In this sense, the tasks of the education system (providing 5 to 6-hour programmes on a day) seem to be too narrowly defined. For more equity in society, it can be expected that, next to preschool provisions, also after-school programmes need to be subjected to priority policy for disadvantaged groups.

Kindergarten and primary school

Kindergarten, and more generally the early years in primary school, do not seem to contribute to closing the early education gaps as much as would be desirable. The current system of granting extra money as a lump sum to schools with a high representation of the ISOTIS target groups does not seem to work: there are no indications that extra funding translates into higher quality and better (compensatory) results. There are, instead, indications that the acceptance of cultural diversity and the way schools deal with diverse classrooms is problematic in some schools, with negative attitudes and lack of trust on part of the teachers, disturbed home-school relationships, polarization in terms of views and values along ethnic-religious lines et cetera (Educational Council, 2017). As such, there lay many challenges ahead for the family and parenting support services in the Netherlands.

2.2.5 COUNTRY PROFILE: NORWAY

Frida Feyer, Henrik Daae Zachrisson

2.2.5.1 Services overall description

The structure of the Norwegian family and parenting services rests on two principles: a main focus on universal programs, and the premise that all services should be available free of any charge. There is a strong public sector in Norway, and most initiatives are public, and services have a holistic approach to family support. The different services are subject to different parts of the public administration. Most family support at the practical level (i.e., beyond universal programs) is provided at the municipal level. In the larger cities, the responsibility is further delegated to the different urban districts. Non-governmental actors are also providing family support at a local level. This is most often not faith-based, as Norwegian government is secularised and is providing services universally and free of charge, but some faith-based actors do contribute; these are mainly Christian, due to Norway's Christian heritage.

The following overall description will be a chronological outline of the available family and parenting support services, from prenatal care, to the end of primary school. Where necessary to provide examples of health care services in larger cities, Oslo, the Norwegian capital, will be used as an illustration.

The Maternal and Child Health Centres (0 - 5 Years)

Pre- peri- and postnatal care

Health centres for children provide maternal health and check-ups for children on a regular basis until school age (when school health services take over). Their main staff consists of midwives, public health nurses, general practitioners and physiotherapists; in addition, the health centre cooperates with municipal psychologists (i.e., psychologists responsible for primary prevention and low-threshold intervention in the community), preschool teachers, family therapists, child protective services and educational and psychological counselling. From the eighth week of pregnancy and onward, the local health centre offers voluntary and free of charge services to families, based on geographic affiliation. Nine maternal health check-ups are available, provided by either a midwife or general practitioner. The health centre then tracks all children from birth, monitoring the child's physical and psychosocial development. Nurses make home visits immediately after birth (within a few days after returning from the birth centre). This is usually one visit, primarily focused on supervision of breastfeeding and baby care. In addition, the health centre offers support and guidance related to the child's motoric and psychosocial development, breastfeeding and breast milk, vaccination, nutrition, dental hygiene, the role of parenting, family interaction, and violence, abuse and neglect. The health centre is also the service that provides and keeps track of vaccination programmes and provides check-ups for children, and therefore is the number one service to monitor the life and health of young children and families up until the age of 5 (when the school health services takes over).

Universal Parental Leave Programme and Child Allowance

Universal parental leave programme includes parental leave for 10-12 months with 100% or 80% salary, up to median income, covered by the government, with employers usually topping that to regular pay. To qualify for parental benefits, the mother (or father when sole caregiver) is

required to have been employed during at least six of the past ten months prior to the parental benefits period. If the parents do not qualify, they may be entitled to a lump-sum grant. The parental benefit period is split in three parts; maternal quota, paternal quota and shared period. Currently, 10 weeks of the parental leave is reserved for the father. These rules apply both in the event of birth and of adoption.

There is also monthly universal child allowances (app. EUR 100/month per child), and tax deductions for child care, and a progressive tax system. The universal child allowances (child benefit) is provided per child, and is meant to cover expenses associated with child rearing and have a redistributive effect on families with children as opposed to families without children. An expanded child benefit can be given to sole providers to cover additional expenditures. For children not attending early childhood education and care (ECEC) in their second year, there is an additional cash-for-care allowance (app. EUR 350/month).

The Early Childhood Education and Care (1 - 5 years)

Early Childhood Education and Care (ECEC) is universal, and children have the right to a slot from age 1. The entitlement to a slot applies to children who turn one no later than the end of October in the year that they apply for a slot. Children born after October will be entitled to a slot the following year. Municipalities are responsible for ensuring the right to a slot is fulfilled, and while they organize this process as a universal coordinated admissions process (covering both public and private centers), they also take into account wishes and needs of the families and the distinctive properties of each ECEC centre. Parental fees are approximately EUR 250/month, with a sliding scale for lower income parents (at the discretion of the municipality; lower income parents pay reduced or no fee, yet this practice differs between municipalities). A restricted number of hours in ECEC per week is free for low-income families for 4 and 5-year olds in all municipalities.

The Kindergarten Act — Kindergarten is the term used for ECEC in public documents in Norway — regulates the matter and form of the Norwegian ECEC, and its purpose is for the ECEC to provide children younger than the compulsory school age opportunities to development and activity, in close cooperation with the home of the child (Kindergarten Act § 1). A framework plan for ECEC has been provided by the government, and it emphasises that a fundamental function of the ECEC is to help children develop social competence, as well as linguistic competence. Seven subject areas have been drawn up as general requirements for the content of the ECEC:

1. Communication, language and text
2. Body, movement and health
3. Art, culture and creativity
4. Nature, environment and technology
5. Ethics, religion and philosophy
6. Community and society
7. Number, space and form

PRIMARY SCHOOL (5-12 years)

Primary School

Education (including university education) in Norway is free, and the Norwegian Education Act

states that all children both have a right to, and are obligated to, attend primary school education from the year they turn 6 years, until they have finished the tenth year of school (end of lower secondary school). That children have a right to primary school education means that all children must be offered a slot in a public primary school. The obligation to attend primary school, however, does not mean that the child must attend a public primary school, and so parents are at liberty to choose a private school or home-schooling, although <2% of Norwegian children attend private schools. All children also have a right to attend a school in their local community, and to counselling if this is necessary for the child to adapt to the school environment.

From the 1st to the 4th grade, the school provides a free homework help service, and from the 5th to the 7th grade, the school is obligated to provide physical activities in addition to physical education (P.E.).

The School Health Service

The school health service takes over from the maternal and child health centres when the child starts attending primary school. It is available at all primary, lower secondary and upper secondary schools, and is responsible for vaccinations and collaborates with the school in offering teaching in classes, as well as individually. Topics for discussion may include medical, psychological, social and developmental issues, and the staff in the school health service may employ a school nurse, school doctor, psychologist and physiotherapist, as well as other health professionals. The school health service is universal and free of charge, and answers all inquiries from children and their families at a primary and secondary school level. In addition, dental services and regular check-ups are free of charge for children until the age of 18.

After School Care

An after-school programme (Aktivitetsskolen) is provided to children in the 1st to 4th grade, as well as to children with special needs in the 5th to 7th grade. This service is regulated according to a framework plan, to assure that the programme contains essential academic content. As opposed to most other services provided to Norwegian children, the after school-programme is not free of charge, and parental fees are approximately EUR 300 per month, with a sliding scale for lower income parents, all the way down to EUR 20 per month.

Targeted Programs

There are also targeted programs (administered by municipalities) for families in need of support (not restricted to low-income or immigrant families, but more often attended by these groups). The types of programs offered vary between municipalities.

The low-income families may apply to the welfare services for income supplement and public housing. Sole providers may apply for transition benefits, financial support for students, *et cetera*. Child welfare services provide a family guidance programme (including International Child Development Program; ICDP), and are currently implementing Family Nurse Partnership (FNP). Other programs include Marte Meo and Circle of Security. All of these programs are provided by municipalities. In addition, with particular relevance for families with non-western immigrants, there are private initiatives providing practical and social support in their local communities. Families may either ask to participate in these programs, or are invited to participate in these programs by their GP or health centre.

Family support programs, like the International Child Development Programme (ICDP), focus on strengthening parent-child relationships. This programme is implemented by the Norwegian Directorate of Children and Youth. Programs like PMTO (Parent Management Training, Oregon Model) or Triple P are offered by municipalities to enhance parenting skills to prevent increases in behaviour problems. Some of the programs, like Nurse Family Partnership (currently piloted in Norway) has a global objective of improving life circumstances for at-risk families and prevent suboptimal development in children, globally. Others, like ECEC (which is universally accessible) has an emphasis on socioemotional development, child well-being, play, and school readiness. Parents are informed about available programs when in contact with health centres, welfare service providers, and health providers. Information is available online.

2.2.5.2 Equality issues (regarding ISOTIS target groups)

In Norway, services have, in general, a goal of providing more equal opportunities for all children. Families are either suggested by nurses at health clinics or GPs to attend these services, or they can seek participation through either GP or health clinics. According to UNICEF (Innocent Report Card 14), the child poverty rate would more than double, were it not for tax deductions, child allowances and other social transfers. Current evaluations of Norway's universal ECEC programme suggest a gap closing.

2.2.5.2.1 Differential access to services

Most services in Norway are universal, or can be attended based on need (typically practical need, e.g., need for parenting counselling), rather than based on income or ethnicity/language background. However, some services specify criteria that a family must meet to be eligible to receive their aid. Some financial aids require that the recipient meet certain requirements; transitional benefits require the recipient to be the sole caretaker of a child, and are meant to ensure sufficient income. Some services, after school-care and the ECEC, charge a fee that is calculated on a sliding scale for lower income parents. To be eligible for a fee reduction, the family is required to document their income. As noted, these conditions exist with the sole purpose of provide a universal service system, with equal opportunities.

A handful of services set criteria related to ethnicity/language in order to target specific users. Children with a first language other than Norwegian have a right to specially adapted language education, until they have a sufficient understanding of Norwegian to keep up with regular schooling. Currently, about 7% of children in school receive specially adapted language education. In addition, children with a native tongue besides Norwegian and Sami (indigenous population in Northern Norway) are entitled to native language education and bilingual education.

With the exception of child welfare services in cases of neglect or abuse, services are not mandatory. The child welfare services provide services after assessing the family's need, and their services are therefore not universally available. The child welfare services may intervene if they decide that the parents do not provide adequate parental care. If this is the case, receiving assistance is mandatory, but this assistance can take on many different forms: parents can be decreed to enrol their child into ECEC, or the family can be subject to regular home inspections. The child welfare services also have a range of services that families at risk may derive advantage from: Parent Management Training Oregon (PMTO), Multisystemic therapy (MST) and Aggression Replacement Training (ART) are just a few examples.

2.2.5.2.2 Targeted Programmes

There are explicit policies to increase participation in ECEC and the labour market for non-Norwegian families. This includes (in some municipalities) “ECEC detectives” who actively seek and recruit families.

A service that has been heavily debated among Norwegian policy makers, is a cash-for-care scheme for parents who stay at home with children between the ages of one and two years. The intention of this service is to provide families with more time and flexibility related to childcare, and to provide financial aid to families who do not enrol their children into ECEC. The service has been accused of keeping children away from ECEC, and has especially been criticised from an integration viewpoint, as more immigrant families than native Norwegian families have accepted the service. Per today, the service has been downscaled and restricted, and programmes intended to direct immigrant families towards the ECEC have been established. Universal programs like health centres and ECEC are well attended (e.g., 94% attend the 4 year check-up at health centres, 96% attend ECEC prior to school entry). Attendance rates of specific programs (e.g., ICDP) are hard to calculate based on the inclusion criteria.

Families are actively recruited to services like The International Child Development Programme (ICDP) through information provided at health centres, child welfare services, etc. Such recruitment is based on whether families are (by nurses or other professionals) considered in need for such services, rather than whether they belong to a particular demographic group.

2.2.5.3 Monitoring

In Norway, there have traditionally been few formal programme- or policy evaluations. Major reforms in the educational and social sector have been implemented without small-scale empirical trials or formal monitoring of implementation quality. This is currently changing. Under the previous and current government administrations, there has been an increasing focus on doing RCTs and other trials prior to reform.

Some publicly funded programs, in particular in health- and child welfare services, are based on rigorous tests prior to implementation (e.g., MST, PMTO), but this approach has until now been the exception. In general, universal programs (e.g., child health clinics) have not been rigorously evaluated. To the extent they are, they most often focus specifically on focal outcomes rather than gap closing. Evaluations of Norway’s ECEC programme have been conducted by academics, showing promising results in closing gaps in short-term socioemotional outcomes (Zachrisson & Dearing, 2015) and long-term outcomes like education and earning (Havnes & Mogstad, 2011). Beyond such academic evaluations, public programs are most often evaluated in terms of user satisfaction surveys or qualitative small-scale reviews (e.g., Bulling, 2016).

Governmental Monitoring

Monitoring of maternal and child health centres, the school health service, the health trusts and other services provided by the municipalities and county administrations is managed at a governmental level, through the Norwegian Board of Health Supervision. They conduct annual nationwide inspections, where one or several fields of activity are selected. The county governors in each county are instructed to inspect that field and report back to the Norwegian

Board of Health Supervision, who compiles an inspection report containing information about that field of activity on a national scale.

Due to capacity constraints, the county governors are to select units in their county to inspect based on their knowledge of the services. This selection is made based on a risk assessment and a goal of making inspection visits to each unit and service regularly.

Monitoring of Maternal and Child Health Centres

The monitoring scheme that is used today was implemented in the late 1990s. Since the beginning, the maternal and child health centres have been subject to supervision three times, in 2008, in 2011, and in 2014. The first inspection focused on the cooperation in municipalities between child welfare services, health services and social services provided to children of compulsory school age. The second and last supervision focused solely on the maternal and child health centres, and their services to children between 0-6 years old. Both these inspections revealed departures from the governmental guidelines, which resulted in a plan for follow-up inspections and corrective actions made by the Norwegian Board of Health Supervision.

The school health service

The school health service has been subject to supervision from the health inspectorate both in 2001 and in 2008. Several deviations from the guidelines were reported and corrective actions set in motion.

Municipal Monitoring

ECEC Centres

ECEC centres in Norway are monitored by the municipalities. This is done by self-reports, and in some instances inspections. Monitoring includes structural and regulatory features; there is no quality monitoring similar to the QRIS-system in the US. The OECD (2015) questioned the adequacy of this monitoring process, given that the municipalities are owners of all public ECEC centres in Norway (approximately 50% of all ECEC centres are public, 50% are privately owned but subsidized in the same way that the public ones are, and covered by the same regulations and requirements).

Services Receiving Governmental Subsidy

The monitoring of services receiving governmental subsidy is delegated to the municipalities and the urban districts. One example of this, is that the publicly managed family centres in the urban districts are responsible for both the granting and monitoring of earmarked governmental subsidies meant to better the language understanding for minority children at preschool age. Another example is that the municipalities are responsible for granting and monitoring earmarked governmental subsidies meant to support services for children and youth in urban communities.

2.2.5.4 Language

Norway has two official languages: Norwegian Nynorsk and Norwegian Bokmål (in essence, these are dialects more than distinct languages). In addition, Sami (the language of the indigenous population in Northern Norway) has an equal status as official language in the two

northernmost counties with high proportion of Sami inhabitants. In addition, Kvensk, Romani and Romanes are recognized as minority languages in Norway and protected through the European Council's charter for regional or minority languages. In addition, through immigration, there are approximately 200 registered languages in use in Norway.

All public services are required to provide (and pay for) translator when necessary. The user of the service can request a translator. In addition, public websites, and information from the health services, are available in several languages, including Sami and the languages used by the largest immigrant populations in Norway.

2.2.5.5 Main challenges

A general challenge in Norway is that because of the strong emphasis on universal programs, everyone is given some services, while the most needy may get less, and resources are spent on supporting wealthy families who would otherwise have paid for the services themselves. This universal versus targeted debate, which is not unique to Norway, has reasonable concerns on both sides. Universal services reduce stigma associated with receiving services, they tend to increase public recognition of the services, and the general public's willingness to pay taxes to fund the services. In addition, Norway has, similar to most countries with an increasing immigrant population, challenges related to integration of immigrants in the labour market and the society at large. An increasing automatization of access to services, through self-service on the internet, increases the risk that the least skilled are denied access because of complicated and bureaucratic application processes.

Maternal and child health centres

While maternal and child health centres are free of charge and widely attended, a recent nationwide inspection by county administrators in 2014 of 78 centres (app. 15% of all centres) revealed that there were systematic weaknesses in the sector, including legal breaches (which were also found in similar inspections in 2008 and 2011). These include: a) poor health examinations (e.g., fewer examinations, or examinations were conducted by staff with insufficient qualifications); b) poor inter-agency cooperation in support for children with special needs; c) incomplete and inconsistent record-keeping; d) poor management by municipalities (breaches are not reported, plans are not taken into account); e) breaches of person protection laws; f) lack of qualified translators.

Family support services

Family support services, including child welfare services, are currently undergoing a major reform, where the local municipalities (of which there are about 420 in Norway) are given greater responsibility. The risk related to this reform is that existing high quality services are broken up and divided, and that especially small municipalities may struggle to establish sustainable high-quality services. The reform may also be an opportunity. Especially child welfare services, but family support services in general, are in many professionals' view characterized by a lack of evidence-based programs, and often an ineffective use of resources. Leading politicians have traditionally been sceptical to research based interventions. With the current national reform called "Renewal of the public sector", there is an overarching increasing focus on research based policy decisions, which may be beneficial for this sector as well.

ECEC

ECEC is the only part of the Norwegian educational system that requires direct payment by the users (e.g., University education in Norway is free). Applying for a slot, and for reduced fees is, as mentioned above, a barrier for many low-skilled families also when it comes to applying for ECEC. Research documents an under-use of ECEC services among immigrants and economically disadvantaged (Zachrisson, Nærde, & Janson, 2013; Sibley et al., 2015). Last year, a national policy providing a limited number of hours per week in ECEC for 4 and 5-year olds from low-income families was implemented, after successful piloting in some districts in Oslo with high proportion of non-western immigrants.

After-school programs

After-school programs are entirely funded by parents, yet municipalities often subsidize slots for children from low-income families. There are large differences in the rates of after-school programs between districts in Oslo and between municipalities in the rest of Norway, but also in the quality of the programme delivered. New of this school year is that after-school programs in some (low income) districts in Oslo, are entirely subsidized by the municipality. Harmonization in both access (i.e., price) and content is a challenge.

Primary school

While the Norwegian school system is mainly public (>2% attend private schools), without tracking before age 16, there are considerable differences in achievement as a function of social background (Ekren, 2014). A recent evaluation of school value added to students' achievement suggests that there are also considerable differences between schools, municipalities, and counties (Steffensen, 2017). Currently, there is a recognition of these challenges, and the government has increased funding both to improve teachers' skills and on research on educational effectiveness.

2.2.6 COUNTRY PROFILE: POLAND

Olga Wysłowska, Małgorzata Karwowska-Struczyk

2.2.6.1 Services overall description

The main sectors involved in supporting the family with young children are: health, social and education, which on the national level are respectively governed by the: Ministry of Health, Ministry of Family, Labour and Social Policy and Ministry of National Education. National regulations are implemented by agencies on different organizational levels ('voivodship', 'poviat', municipality). The families may use universally accessible services provided by public organizations and the services provided by non-public organizations (to some extent financed from public resources). The non-public sector may have secular or religion-based character (predominantly Christian).

Health Sector

Health care is funded through the National Health Fund (*Narodowy Fundusz Zdrowia*; NFZ) within the scope regulated on the national level. Medical services are available free of charge to all children up to 18 years of age who are Polish citizens, have the refugee or subsidiary protection status or a temporary residence permit. As far as adults are concerned, the ones entitled for medical care are: the Polish citizens who are insured, pregnant women (health care services are limited to prenatal and postnatal care) and low-income families living on the territory of Poland (citizens, refugees, with the subsidiary protection status or a temporary residence permit).

Children and pregnant women are among the groups of particular support of the sector. Mothers-to-be may be beneficiary of tailored programs, for example recently developed Pro-life programme (*Za życiem*), providing additional support (financial, medical and psychological) to parents expecting disabled children, and universally available programs concerning pre-natal care (childbirth classes, periodical check-ups etc.). Depending on the age of the child different obligatory and voluntary services are available, e.g.:

- post-natal care in the form of home visits by a nurse and midwife to monitor the new born child's conditions of living (especially hygienic conditions), identify family risk factors, provide parents with advice on breastfeeding, nutrition, disease prophylaxis, promotion of healthy living, etc.;
- health monitoring, counselling and treatment, for example periodical check-ups to identify the needs for early intervention and targeted services, basic vaccination, hospitalization;
- free medication (applies to the medicines from the list regulated by the Ministry of Health).

Non-public providers may deliver publicly funded health care services (reimbursement of the costs is based on the contracts with the NFZ); in that sense all parents have a choice of the provider. In practice, a small number of private medical facilities decide to apply for public financing or it takes place on limited scale (in terms of both the number of places and types of treatment). Hence, even though since the political transformation private health care sector has been dynamically developing, public institutions are still the dominant providers of these

services. Importantly, regardless of the national regulations ensuring access to free of charge medical services to all children and pregnant women, not all of them receive necessary support. Two main reasons for that are insufficient financing of the health sector (treatment of some diseases is not covered, there are long waiting lists for specialist services etc.) and bureaucracy, which may be discouraging especially for most vulnerable families (for example several documents from different institutions are required to apply for rehabilitation treatment of a child).

Education Sector

The education system in Poland provides universally accessible, free-of-charge services for children from 3 years of age. Compulsory education starts at the age of 6, when children are obligated to attend one year of school preparation (*zerówka*). From the school year 2017/2018 primary school lasts 8 years (the three first years are considered lower-primary school). Primary school may be followed by high school (4 years), technical school (5 years) or vocational training (3 years + optionally 2 years).

Institutional educare for 3-6-year-old children

Children from 3 up to 6 years of age are entitled to 25 hours of educare free of charge (5 hrs a day/ 5 days a week). It may be organized in public preschools or other forms of preschool centres (also non-public ECEC centres subsidised by municipalities). Fees for additional hours of care in the centres are regulated on the municipality level (except the care of 6-year-olds, which is free of charge). Meals for all preschool children are paid for by parents. Low-income families may apply for discounts or exemptions from fees for both meals and additional hours of educare.

The National Curriculum Framework for Preschool Education states that education institutions are to collaborate with parents and the communities which the parents consider important for the development of their child's identity. Teachers are obligated to systematically inform the parents on their child's developmental progress and encourage them to collaborate in fulfilling educare program. In practice, the types of activities involving parents vary between the centres. Some of the centres use more passive strategies to collaborate with parents, for example limit their activity to providing parents with information (information boards, leaflets, websites, registers etc.). Others introduce active forms of cooperation, such as organizing meetings and workshops for parents with specialists (speech therapists, psychologists), organizing open days or events and celebrations providing opportunities for exchange between parents and staff, or inviting parents to get involved in the implementation of the curriculum framework, for example by presenting their profession to children, inviting children to their place of work, reading to children.

Psycho-Pedagogical Counselling Centres

All parents of preschool and school age children are entitled free of charge to the support of Psycho-Pedagogical Counselling Centres. These local providers are responsible for planning and implementation of actions aimed at quality improvement of educare services, inter alia by diagnoses of children and adolescents, direct psychological and pedagogical assistance for children, adolescents and parents, preventive actions and support of the educare role of kindergartens, schools and other institutions, organization and implementation of support for

kindergartens, schools and institutions in providing academic and social education and care. What the centres can offer is framed by the national regulations; nevertheless, the needs of local communities are taken into account when planning the work of each centre, hence the provided activities may have the more family-focus (family therapy, parental support groups, workshops etc.) or child-focus (individual therapy, counselling etc.) character.

Social Sector

One of the main groups of social assistance beneficiaries are families and children (Law of 12 March 2004 on Social Assistance). The assistance is organised by public administration in cooperation with organisations such as foundations, associations, the Catholic Church, other churches and religious groups, employers and both natural and legal persons. In 2015, non-public institutions were financed with public resources in almost 50% and in that sense they are to a large extent operators of the public strategy of social assistance.

Institutional educare for 0-3-year-old children

Institutional care for children under the age of three is under the supervision of the Department of Family Policy (it is not part of the education system). Children from 20 weeks up to 3 years of age may attend crèches, or be under the care of day care providers (*dzienny opiekun*) or a nanny. Children from 1 up to 3 years of age may be enrolled to day care centres. The legal guideline states that professionals working in crèches and day care centres as well as day care providers are to collaborate with parents, provide them with advice and consultations concerning the children's upbringing and nutrition. However, this cooperation on many occasions does not go beyond passive strategies, such as providing information to parents when they bring the children to the centre or pick them up.

Family Assistants

One of the very few home-based non-financial support programs dedicated to families with children in a difficult life situation is the Family Assistant. The Family Assistant is a specialist who provides support to the families in the place of living, or other location chosen by the families. Assistants are primarily responsible for the collaboration with families which is aimed at overcoming the problems they are facing by providing psychological, social and legal support (directly and/or non-directly by referring the families to specialists), encouraging social activity, supporting job searching and keeping the job, motivating for participation in parental support groups and cooperation with local providers of social assistance and educare services. The amount of time dedicated by family assistants to particular families is regulated on the local level, most often it is 2-5 hours a week. The participation in the programme is voluntary and free of charge. The specific rules and the scope of collaboration are formulated in a written document, a contract, which the family and the assistant agree on at the initial phase of the cooperation.

Non-public support for families in difficult life circumstances

In Poland there are thousands of NGOs operating on the local, regional and national levels which directly or indirectly (for example by equipping infant hospital wards) support families with young children. Examples of non-governmental organizations operating on the national level are: *Caritas Polska*, providing for example food supplies and psychological support (individual

consultations, group therapy), and co-financing/financing holidays and extracurricular classes for children; *Fundacja Dajemy Dzieciom Siłę* focusing its actions on the psychological support of the families (parents and children) with abuse problems (also prevention, awareness campaigns); *Stowarzyszenie Wiosna* implementing programs such as *Akademia Przyszłości* (mentors for children from disadvantaged families) or *Szlachetna Paczka* (preparation by individuals or communities of Christmas parcels for disadvantaged families - food, clothes, furniture, home appliances etc.; in 2016 over 18,000 families received support from over 750,000 donors).

Universal parenting support programs

Public providers at all administrative levels are responsible for the organization and implementation of programs aimed at supporting families with children; the programs vary in terms of scope and goals. An example of a national programme is *Karta Dużej Rodziny* (the Large Family Card), the card allowing for discounts and privileges for families with three and more underage children (up to the age of 25 when the children are studying); the card is valid in thousands of public and non-public cultural, tourist, transport etc. institutions in the whole country. One of the objectives of the programme is to encourage and enable whole families to spend more time together on cultural, social and educational activities. Parenting support as broader education is also offered by a number of non-public organizations, for example by NUTRICIA Foundation which is the leading partner of the 'The First 1000 Days' educational programme, the biggest Polish educational programme devoted to the nutrition of pregnant women, babies and toddlers.

2.2.6.2 Equality issues (regarding ISOTIS target groups)

Health Sector

Health care services are oriented to reducing inequalities by their universal and free-of-charge accessibility (within the scope formulated by the Ministry of Health). Basic services, such as family doctor consultations, are self-referral, whereas specialist support is professional referral (e.g., by family doctor, social services, court). The vast majority of services is volunteer, some, such as vaccination of children (basic package), are mandatory. To reach all the families with children, information on the available health care services and patients' rights is provided in all medical facilities. Starting from the hospital where the child is born, mothers receive informational materials on infant and toddler nutrition; they may ask for advice on the available health care, social support and advice and/or support from the breastfeeding specialist. Furthermore, a midwife and a nurse provide information to the family on their rights and obligations in regard to the child's health care (obligatory home visits). Then, the family doctor monitors the child's medical condition, for example obligatory vaccination. Public and non-public institutions organize information campaigns targeted at increasing parents' knowledge on the most common threats to children's health, for example obesity, alcohol and drug abuse or internet/TV addiction.

Some forms of financial support, for example *becikowe* (benefit for the family of a new born child), are available to low-income families on conditions, inter alia being under health care supervision of a doctor from the 10th week of pregnancy.

Education Sector

The education sector provides universal and free-of-charge access to educare services to children from the age of three, hence ensures equal educational opportunities to all. ECEC centres and schools have a universal obligation to implement educare programs which take into account the needs of the particular group of children and the needs of each individual child (Act on the Education System of 1991). In that sense, the regulation implies that teachers who are working with children from low-income/at risk families should adjust educare programs to their needs.

Participation in all extracurricular activities is voluntary and may be based on self- or professional referral (predominantly self-referral).

An important role in supporting children and families in difficult life circumstances is played by non-public organizations, who finance the low-income children's participation in educational extracurricular or compensatory activities or provide such services themselves. For example, *Starszy Brat, Starsza Siostra* ("Older Brother, Older Sister") is a programme directed to children requiring educational and emotional support. Help to children is provided on a regular basis (usually one afternoon a week) by the same appointed volunteer for a longer period of time (for 1-2 years). The type of the support provided by the volunteer depends on the individual child, but most of all it is focused on building positive self-esteem of the child and overcoming educational problems. The motto of the programme is "The bigger help the smaller, the stronger support the weaker".

Additionally, there are information campaigns, mostly organized on the national or voivodship level, encouraging parents to be actively involved in their child's life, for example the national campaign *Rozmowa to wychowanie* ("Conversation is upbringing"), organized by *Fundacja Mamy i Taty* (the Mum and Dad Foundation), underlining the importance of talking day-to-day even with the youngest children, or *Cała Polska czyta dzieciom* ("All Poland reads to children") highlighting the importance of reading books to and with children.

Social Sector

All cash benefits and non-financial social support services are oriented to reduce economic/social class inequalities, as well as encourage greater activity and independence of the most vulnerable. Social assistance is granted inter alia for the following reasons: poverty, the need to protect motherhood, unemployment, incompetence in childcare matters and running a household, particularly in the case of incomplete and large families. Most services are voluntarily and targeted (potential beneficiaries have to provide documents proving their difficult life situation). On some occasions the court may decide on the need to intervene in the family situation, for example by assigning a legal guardian to a family, a specialist who is to monitor the home conditions of the family (with particular attention to children) and to moderate the cooperation of the family with social, health and educare services. The cooperation of the family with the legal guardian is coerced.

The implementation of family support programs is predominantly regulated on the local level. Some municipalities, for example Warsaw, elaborate complex, inter-agency strategies. Plan of action is then based on the diagnoses of the local communities' needs. It influences for example the choice of financed/co-financed social support programs (provided by public and non-public stakeholders) or the location of social services agencies. One of the implemented strategies of supporting families with children is establishing *Lokalne Systemy Wsparcia* (LSW;

Local Support Systems). LSW include NGOs operating in the same neighbourhood, which create and implement tailored programs. In order to provide families with a holistic support, LSW cooperate with local public service providers (health, care, education, social activation). Actions provided by LSW are predominantly publicly funded.

In terms of institutional educare for 0-3 year olds in the public sector, children's stay is financed by the municipality and parents (the fees are regulated on the level of municipalities). Families in difficult life circumstances may apply for reductions or exemptions from payment. Additionally, some municipalities formulate recruitment procedures prioritising access to educare services to children from low-income families, with special needs or being under the care of a single parent.

Another action supporting families is *Mama i tata wracają do pracy, a ja idę do żłobka* ("Mum and dad are going back to work and I'm going to the crèche"), a programme dedicated to unemployed parents of the youngest children. In order for the child to be enrolled to a public crèche (admission is limited due to insufficient supply of service), the parents are obligated to start work or participate in a professional training organized by Employment Office within 6 months of the child's enrolment to the crèche.

2.2.6.3 Monitoring

Central Statistical Office of Poland (*Główny Urząd Statystyczny*; GUS) gathers data on the cost and coverage of different services across the country. Cyclic reports provide information on national and voivodship levels. Some of the presented data refer to the ISOTIS target groups, for example, expenditure on the benefits for low-income families with children. Additionally, municipalities collect data on the implementation of locally provided programs which should be taken into account while planning local family assistance strategies. Additionally, municipalities collect data on the implementation of locally provided programs which should be taken into account while planning local social assistance strategies.

Health Sector

Three basic aspects of health care services quality are monitored and/or evaluated: structural quality (for example: level of professional training, medical apparatus, organizational structure), process quality (diagnosis and treatment) and outcome quality (level of patients' satisfaction, mortality and morbidity statistics).

Generally, medical facilities are externally evaluated for compatibility with ISO norms, especially concerning the establishing, documentation, implementation and maintenance of the quality management system and continuous improvement of its efficiency, or accreditation standards elaborated by the Centre for Monitoring Health Care Services Quality (*Centrum Monitorowania Jakości w Ochronie Zdrowia*). Additionally, the law states that monitoring of services provided has to take place on the level of each medical facility.

Regardless of whether the evaluation is systematic or one-off, the conclusions of monitoring and evaluation should be fed back into the system. There are no specific regulations concerning the improvement of the accessibility or quality of health care services targeted at ISOTIS target groups such as low-income families; monitoring and evaluation are focused on improving the system for all citizens.

Education Sector

Pedagogical supervision over the educational institutions (including monitoring and evaluation) takes place on different administrative levels: national (Minister of Education: choice of national priorities of pedagogical supervision; specifying number and type of institutions which are to undergo external evaluation), voivodship (voivodship superintendent: coordination and implementation of the pedagogical supervision; implementation of external evaluation), municipality (Head of Department of Education: direct supervision over the institutions) and the educational institution (principal / head teacher: day-to-day supervision).

Accordingly, the pedagogical supervision may have an external or internal character. In general, supervision over the services concerns: evaluation of educare services, implementation of legal acts regulating the work of educare sector, support for institutions in providing educare services and in implementation of other statutory actions. The results of pedagogical supervision are supposed to be used for creating strategies aimed at the improvement of educare services.

External evaluation is characterised by systematic and one-off actions. It may concern a selected aspect (or several aspects) or overall service provision and should meet the requirements of transparency, flexibility and involving all stakeholders - parents, teachers, directors, the local community and other organizations. The results of external evaluation (of the process and outcomes) are publicly available at the SEO platform (System of Educational Sector Evaluation platform). The education institutions which performed below expectations (each evaluated aspect may be assessed on a 5-point scale) are obliged to prepare and implement an improvement plan. In general, monitoring and evaluation are focused on improving educare quality to all stakeholders.

Social Sector

The government administration at the central and voivode levels is responsible for assessing the conditions and efficiency of social assistance as well as supervising the quality of activities and the observation of standards in the services provided by social assistance units in powiats and commons. The general trend is that on the lower levels of the system (district, municipality) there is more focus on monitoring and evaluating the process, whereas on the voivodship and national levels the focus is on the structure of the system and statistics. The statistical data are especially taken into account in terms of planning the expenditure on the social assistance tasks in the national budget.

2.2.6.4 Language

Health Sector

The regulations of health sector do not address issues concerning language acquisition. General information concerning the sector is available in English at the web-site of the Ministry of Health. Some specialist centres for refugees provide the assistance of interpreters. In most of the private medical facilities specialists speaking English are available.

Education and Social Sectors

Members of different non-Polish-speaking groups are entitled to different types of support in Polish and/or mother language acquisition provided by public institutions.

Polish citizens belonging to the national or ethnic minorities or communities using regional languages specified in the *Act of 6 January 2005 on National and Ethnic Minorities and Regional Languages* are entitled to a wide range of support aimed at the sustainment of the languages and cultural heritage. The support may concern for example educare of children, cultural sector (subsidising minority libraries, social events, the press etc.), public administration (availability of using the language in some municipalities as an official language). The national minorities listed in the act are: Belarus, Czech, Lithuanian, German, Armenian, Russian, Slovakian, Ukrainian, Jewish; and the ethnic minorities are: Karaim, Lemko, Roma, Tatar.

The issue of language acquisition of Polish citizens who are non-Polish speakers and do not belong to a minority group according to the act is not addressed in legal regulations apart from educare regulations. Foreigners who have or have applied for a refugee status or subsidiary protection may apply for subsidies for Polish language courses. Additionally, there are different non-public providers offering language courses to all non-Polish speakers (some of them are free of charge), and public and non-public organizations providing support to non-Polish speakers in filling in or translating documents, information searches, legal issues etc.

The National Curriculum Framework for Preschool Education (children 3-6 years of age) lists 17 areas of child development which are to be supported by an ECEC centre in order to reach the goals of preschool education. One of the areas is: *Preparation for the use of the language of a national or ethnic minority or the regional language of children belonging to the national and ethnic minorities and the communities using the regional language*. The National Curriculum Frameworks for School Education (primary and secondary schools) also refer to the issue of regional languages and the languages of national or ethnic minorities. According to the regulations, one of the school's tasks is to support minority children's language acquisition and their cultural, historical and ethnic or national identity. In terms of both preschool and school the regulations refer to the minorities listed in the act. Depending on the type of preschool provision and school level the number of language classes per week varies, but it is not less than 3 (geography and/or history of the country/region may be taught in that language). Classes of national or ethnic minority or the regional language are free of charge and are organized by the principal of the ECEC centre or school upon written request of parents.

Children who do not speak Polish are entitled to up to 5 hours a week of extra-curricular classes of Polish language and other school subjects in Polish (public sector). They may be individual or group classes and are organized by the principal of the ECEC centre or school.

2.2.6.5. Main challenges

Challenges regarding the support system of families with children vary across the country, as to high extent this sector is regulated locally. However, some of the challenges concerning support to low-income families and children (one of the ISOTIS target groups) seem to be common across sectors and organizational levels.

The most urgent issue seems to be the lack of or limited access to targeted prevention and early intervention programs directed to at risk families, especially home-based programs. Access to the services is especially limited for families living in rural areas. One may say that the situation of the family has to be very difficult to get support (except financial benefits).

The other challenge concerns the lack of or the limited scope of effective inter-sector cooperation mechanisms. For beneficiaries it results for example in the need of multiplying documents required to access different kinds of services or benefits, even within the same

sector or institution. The consequence for professionals, especially non-public providers, is that on many occasions they are competing with one another in order to get the financing instead of cooperating. Additionally, specialists from all sectors are obligated to use an increasing amount of time on bureaucratic tasks (often multiplying documents), which leaves them less time for direct work with beneficiaries.

Due to the insufficient number of places, across the whole country, especially in the rural areas, there is a problem with access to the institutional early childhood education and care for children 0-3 years of age.

Finally, evaluation mechanisms and research on the effectiveness of support programs are missing. Currently evaluation predominantly is focusing on structural characteristics, mostly based on documentation.

2.2.7 COUNTRY PROFILE: PORTUGAL

Joana Cadima, Gil Nata

2.2.7.1 Services overall description

Portugal's early childhood services and family support involve several sectors, namely education, social and health. Currently, children have access to universal health care and, starting at the age of 4, universal education, through public services. Regarding social support for children and families, the Portuguese social policy is characterized by a strong partnership with the third sector, with local private, non-profit, publicly-subsidized institutions playing a key role in the delivery of services (Perista et al., 2013; Wall et al., 2014). Currently, public support to families in exercising parental functions is very low, given that services and resources specifically addressing parents' needs are not part of public policy. In general, parenting support for children below six years old is implemented on a voluntary basis and through ad hoc initiatives (Eurofound, 2012), with the exception of the health sector, the only sector in which public programs and interventions on parenting support are carried out regardless of family income or their social conditions.

Public health services for parents and children

The national health programme for pregnancy established in 2015 follows a comprehensive perspective based on three axes: (i) a person-centred approach, (ii) continuity of care throughout life and (iii) pregnancy as opportunity for intervention and change. Among several goals, health services aim to prepare expectant women and their partners to parenthood (DGS, 2015).

a) Maternity care is covered by the national health system and is free for all pregnant women. Prenatal care in low-risk pregnancy is mainly provided by general practitioners and nurses at the local health units, such as health centres and family health units (DGS, 2015). In case of health problems, the expectant mothers have access to specialized care in public maternity hospitals. The number of prenatal visits, laboratory evaluations, and ultrasound examinations performed in low-risk pregnancy are established at the national level (DGS, 2015).

b) Prenatal classes usually take place at healthcare centres and public maternity hospitals, and are organized by nursing teams. The classes aim at preparing parents for labour, birth and early parenthood (DGS, 2015). The sessions usually cover topics such as labour, pain relief choices, and practical baby care and breastfeeding; they also include strategies for pain management during labour such as relaxation and breathing techniques. The sessions are intended to help expectant women and their partners to build their confidence, discuss their fears, as well as to equip them with basic information about labour and parenthood (DGS, 2015). All prenatal classes are free of charge.

c) Children and youth up to 18 years have free universal health care (DGS, 2013). There are regular check-ups to evaluate children's development and growth, provided at the local health centres by general practitioners. Healthcare settings are also responsible for the National Immunization Program. Immunization rates among children are very high, with more than 95% of children receiving vaccines (DGS, 2013). Health services provide information to parents about nutrition, healthy lifestyle, and safety measures at home. Parents also receive a Health

Booklet in which ongoing medical information is recorded and written information for parents is available. Services are also expected to offer overall screening to detect mental health problems, developmental delays and to identify any possible neglect or maltreatment. Specialized services such as paediatricians are accessed through referral by the general practitioners (DGS, 2013).

Social support to families

Universal benefits for families granted by the social security system include maternity and paternity leaves. Other social benefits and support to meet family needs are dependent upon family's income and have changed considerably in the past years. Since 2010, after a period that favoured a pro-family and pro-egalitarian perspective, cash benefits for families have changed with a) increased selectivity, and eligibility criteria focusing on support for families with very low income, and b) reduction in the amounts of benefits (Wall, 2014). Tax reliefs for families were also cut back (Wall et al., 2014). These developments in family policies have had an impact on public spending on benefits and services for families, both of which have dropped (Wall et al., 2014). Even though a set of benefits for families were applied during the economic crisis, namely an increase of unemployment benefits for couples where both parents were unemployed, and the "Social Emergency Program", which provided support in kind (e.g., food, clothes) to reach out to families in extreme poverty, according to UNICEF (2013) the economic vulnerability of families has increased, as well as child poverty rates.

Regarding parenting services, between 2007 and 2010, important strategic reforms took place aiming at improving the system of social protection for families, following Children's Rights Convention and the recommendation of Council of Europe (2006) that encouraged states to recognize the importance of providing parents with support. This line of action was however suspended with the economic crisis. At that time, the ministry of labour and social security commissioned two important actions with an explicit focus on positive parenthood:

a) *Positive Parenthood Program*: within a collaborative protocol between the National Commission for the Protection of Children and Adolescents at Risk, Institute of Social Security, the Directorate-General for Health and Social Security, and five public universities, a study involving a national inquiry on all parenting education initiatives was developed aiming at evaluating the effectiveness of parent education programs, as well as to inform policy making by providing guidelines for regulating parenting education programs (Abreu-Lima et al., 2010; Almeida, 2012).

b) *Family Support and Parental Counseling Centres* were created in 2007, designed to provide a social response for families with at-risk or maltreated children. These centres offer targeted services to children and families in situation of danger or risk, and since 2013 their intervention is framed by positive parenthood principles, with the aim of strengthen families in their parental exercise. The services are carried out by multi-disciplinary teams at private non-profit institutions.

Early childhood services: Crèches (0-3 years)

Formal early childhood settings for children between 4 months and 3 years old include both centre-based care and home-based care, although the latter is considerably less used. The centre-based settings, known as crèches, are not part of the education system but rather are under the tutelage of the Ministry of Labour, Solidarity and Social Security. According to the

Portuguese government agency responsible for infant and toddler child care in Portugal – The Social Security Institute (ISS, 2005) - crèches have the double goal of supporting families, in particular by facilitating the reconciliation of family and work life, and to provide each child with opportunities that foster his/her global development and social integration. Although there is no steering curriculum document, there are some pedagogical guidelines issued by the Social Security Institute in 2005 that emphasize that a) pedagogical activities should promote child well-being, b) children's learning and development should occur through play and within a context of close relationships, and c) a close partnership with families should be promoted (ISS, 2005).

Crèches are mainly organized at the local level and almost all are private institutions. The vast majority (nearly 75%) are non-profit, public-subsidized, although in some regions, especially in Lisbon, for-profit crèches can reach a total of 40% (ISS, 2015). Indeed, the distribution of crèches throughout the country is not homogenous and, in some regions, especially in the larger urban areas, demand is higher than supply (ISS, 2015). As a result of several investments to expand day-care services, the coverage rates have increased substantially over the last few decades (ISS, 2015). Specifically, there was a growth of 70% of crèches from 2000 (nearly 1600 crèches) to 2015 (nearly 2600 crèches and 117 000 placements). In 2015, 43% of children aged 0 to 3 benefitted from childcare services, whereas in 2006 this figure was around 33%. From 2007 to 2010, the Ministry of Labour and Welfare launched a program, the Social Services and Equipment Network Extension Programme (PARES) to invest in new publicly-funded care services for children below age 3. In 2011, this programme was suspended. Nevertheless, the coverage rates continued to increase between 2011 and 2013 as a result of a change in the Portuguese legislation in 2011, that increased the upper limit of children per group and child: adult ratios (Portaria n. 262/2011, August 31st).

It is important to note that Portugal has one of the highest rates of mothers working full time in the European Union: in 2011, 76% of Portuguese mothers were in the workforce, which contrasts with the average of 57% of the European Union (OECD, 2011), which is presumably related to the comparably shorter paid leaves period (see section 2.1.4 above). Similarly, crèches in Portugal generally provide extensive opening hours. In 2015, the average hours of provision were 39.5 hours per week, which again contrasts with the average of 26.5 hours in the European Union. The service has costs for families. In public-subsidized institutions, parents are expected to pay a fee, which is calculated based on their income.

Education: Early childhood services for children (3-6 years)

Starting at the age of 3, children are legally entitled to free early childhood education. Attendance in preschool is not compulsory but it is viewed as the first step of the Portuguese Education System in a lifelong learning process (ME, 2016). In 2009, the Government established universal access to preschool education for 5-year-olds, which was extended, more recently, to 4-year-olds (Law 65/2015). Portugal has national curriculum guidelines for preschool education, officially approved by the Ministry of Education in 1997, and recently revised, in 2016. The curriculum guidelines constitute a set of general pedagogical and organizational principles to support childhood educators in the educational process, based on the following principles: development and learning are inseparable; children are active subjects of the educational process; knowledge is integrated rather than compartmented (ME, 2016). The main pedagogical objectives of preschool education are: a) to promote children's personal

and social development, based on democratic life experiences; b) to foster children's integration into diverse social groups; c) to contribute to equal opportunities in school access and learning success; d) to stimulate children's global development; e) to promote expression and communication development; f) to enhance curiosity and critical thinking; g) to provide children with situations of well-being and security; h) to identify maladjustments, disabilities or giftedness and i) to encourage families to participate in the educational process (Law 5/97).

Regarding family involvement, according to this steering document, teachers are expected to view families as partners of the learning process and to engage parents in a dialogue to ensure that parents play a role in the education of their children. The document recommends that teachers develop a meaningful and respectful relationship with parents, through diversified actions, including visits to preschool, group information sessions, and formal and informal bilateral parent-teacher meetings, in which expectations, suggestions, and needs are shared and exchanged (ME, 2016). In a recent nationwide study on parental involvement practices, it was found that more intensive collaboration such as courses for parents, or home visits were rarely organized (Abreu-Lima et al., 2014).

The Portuguese preschool network includes public (61%), private for profit (18%), and private non-profit centres (21%), all of which are under the pedagogical guardianship/tutelage of the Ministry of Education. The curriculum guidelines for preschool education were designed to provide a common reference for all preschool teachers across the entire network, and the Ministry of Education is responsible for ensuring the pedagogical quality of teaching of all institutions, irrespective of their institutional nature. Public schools are free for children, whereas in private institutions, parents pay a fee. In non-profit institutions, similarly to crèches, through cooperation agreements with the Social Security in which centres receive public funding, parents pay a fee according to their income. The national network has rapidly increased in the last 20 years, from 57% in 1993 to 95% in 2011. The educational component includes five daily hours in a total of 25 hours per week. The vast majority of public preschools are integrated into schools' clusters that also integrate primary and secondary education schools (Decreto-Lei n.º 137/2012). The creation of school clusters aimed to reinforce the coherence of the curriculum throughout the cycles of studies, favour transition, prevent social exclusion and optimize human and material resources.

After school care

Since 2006, the Ministry of Education created a Family Support Service targeting preschool and primary school children and their families, designed to extend schools' opening hours to full-time 8-hours per day. In addition to 5 hours of education, preschool children, as well as primary school children, started to have before and after school care. For primary school children, after school care included two hours of extracurricular activities (including English, music, arts and crafts, etc.) at schools. However, since 2011, even though the 8-hour school day was maintained, the number of hours of extracurricular activities was reduced. Funding for the extracurricular activities was also reduced, with a shift of the responsibility for organizing these activities to schools, parents' organizations, and local authorities (Dispatch No. 9265-B/2013).

2.2.7.2 Equality issues (regarding ISOTIS target groups)

2.2.7.2.1 Differential access to services

Health

There is universal access to prenatal care, which is free for all women during pregnancy, irrespective of their legal status. Free universal health care is also provided to all children and youth up to 18 years old. Even though there is universal access to prenatal health care, empirical studies have suggested that immigrant women were more likely to receive late or no prenatal care (Almeida, Santos, Caldas, Ayres-de-Campos, & Dias, 2014). According to these studies, delayed access to prenatal care and reduced number of prenatal visits in immigrants were related to differences in health expectations regarding prenatal care, unawareness of the options available to immigrants, economic difficulties in accessing healthcare centers, and/or communication difficulties with staff (Almeida et al., 2014). Moreover, a recent review of the Portuguese national health system to the European Observatory on Health Systems and Policies (Simões, Augusto, Fronteira, & Hernández-Quevedo, 2017), highlighted asymmetries in health care access across the country. According to the report, even though the geographic distribution of healthcare settings is adequate, with less than 1% of the population living more than 30 minutes away from a health care facility, its distribution is not equal across regions. Importantly, in municipalities with higher rates of younger populations (less than 14 years old) the ratio of general practitioners per 1000 population is lower (Simões et al., 2017). Other barriers that limit equal health care are related to disparities in income and education. Indeed, according to the report, health inequalities remain one of the key challenges for the Portuguese National Health System (Simões et al., 2017).

Social support to families

After the 2008 economic crisis, social benefits for families were severely reduced (Wall, 2014). Several benefits that were previously offered to the majority of families were abolished including financial support for expectant mothers and the uprating of social benefits for every third and subsequent child (Wall, 2014). The eligibility criteria for entitlement to social benefits started to be more restrictive, both in terms of cash and number of beneficiaries. Even though new family measures were introduced during this period, aiming at mitigating the social impact of austerity on the most vulnerable groups, these measures only targeted families in extreme poverty, excluding low-income families (Peristo, 2013). For instance, the Portuguese Government launched in 2011 the Social Emergency Program, implemented through third sector institutions, with a clear focus on providing additional support in kind (e.g., canteens, free breakfast at school) for families in extreme poverty. Additional measures for families with children included an increase in unemployment benefits for unemployed couples with children and unemployed single parents. However, in both cases, entitlement was dependent on the level of income of these families, with a threshold that excluded families in need and low-income families (Wall, 2014). According to Perista (2013), in regard to social benefits, since major cuts were implemented, the State reduced by 30% its expenditure on support for families with children and one third of beneficiaries lost access to child benefits.

Crèches

In public-subsidized, not for profit institutions, parents are expected to pay a fee, which is

calculated based on their income. In cases in which demand is higher than supply, the Social Security Institution recommends priority to families with fewer economic resources, single parents or large families, and working parents (ISS, sd). However, crèches have freedom to set up their own criteria to allocate available places (Portaria n. 262/2011). In fact, according to OECD (part 1a), participation rates vary across socio-economic groups, with higher participation rates among the most economically advantageous families (59,5%) compared to the lower income families (36%).

Education: Early childhood services for children

Regarding preschool education, children are entitled to free access starting at the age of 3, in public schools, which represent nearly 61% of the preschool network. In private settings, parents pay a fee, which is income-dependent in non-profit settings. Attendance rates are very high.

2.2.7.2.2 Targeted Programmes

Social protection for families

Targeted social measures currently implemented in Portugal that provide parenting support for families include a) Social Integration Income, designed to support extremely poor families, and b) Family Support and Parental Counseling Centres, designed to support children and young people in situations of danger and their families.

a) The *Social Integration Income* (Rendimento Social de Inserção) is a special social and financial benefit for families in extreme poverty, designed to meet families' basic needs and to promote social integration and participation in society. State protocols are established with publicly funded private institutions, which are responsible for implementing the program. The service aims to facilitate access to social and economic autonomy through an individualized support to families that includes, in addition to a cash benefit, a protocol agreement that, depending on the situation of the family, may involve family duties such as participation in training courses, school attendance, or active job search. Participation in parental education courses may be available and may be even compulsory in some cases. However, there are no specific guidelines for the procedures and measures to be used. The number of individuals and families benefiting from this social measure has been continuously reduced since the economic crisis, as a result in changes in eligibility criteria, from nearly 500 000 in 2010 to 287 473 in 2015 (PorData). In 2017, eligibility criteria were changed again, in order to dignify the programme and reinforce its inclusive aim (Decreto-Lei 90/2017), which will result in an increased number of beneficiaries. In October 2017, 213 649 individuals were benefiting from RSI and 32,2% had less than 18 years (GEP, 2017).

b) *Family Support and Parental Counselling Centres* are private publicly subsidized institutions that provide support for families and children in situations of social risk and maltreatment. These services were regulated in 2013 and include a specific focus on positive parenthood. In 2016, 80 centres were operating in Portugal (Alves, 2017). Multidisciplinary teams are responsible for the assessment and development of an intervention plan, tailored to families' needs. However, in a recent study involving 46 centres, it was found that professionals lack supervision, intervention guidelines, and opportunities for professional development (Alves, 2017).

Education: TEIP

The Educational Areas for Priority Intervention (Territórios Educativos de Intervenção Prioritária [TEIP]) is a nationwide programme designed to reduce the effects of socioeconomic disadvantage on school outcomes and to promote equity and social inclusion from an early age. The programme targets schools (or groups of schools) in deprived geographical areas and, consequently, children at risk for poverty and social exclusion. The programme intends to improve the quality of learning experiences and students' academic performance; to decrease early school leaving, absenteeism and students' indiscipline; to facilitate a qualified transition from school to active life and to empower schools as critical and useful educational and cultural agents in their communities. Schools covered by the programme benefit from extra financial and human resources, such as more teachers, assistants and specialized staff (e.g. social workers, social educators, psychologists). Schools also have an external expert who advises schools based on their needs. Currently, nearly 10% of schools and 11% of all students enrolled in the public education system are involved in a TEIP program.

Inter-sector (health, social, and education) programs

ACM – Escolhas

Escolhas (“Choices”) is a nationwide programme that aims to promote children and youth social inclusion in deprived socioeconomic contexts, particularly in areas where descendants of immigrants and ethnic minorities are concentrated, in favour of equal opportunities and stronger social cohesion (Resolution of the Council of Ministers n. 101/2015; Matos Simões, Figueira, & Calado, 2014). It was created in 2001 by the Presidency of the Council of Ministers and it is coordinated by the High Commissioner for Migration. The programme includes five strategic areas of intervention: (I) Education and Professional Training; (II) Employment and employability; (III) Civic participation, civic rights and duties; (IV) Digital inclusion; and (V) Entrepreneurship and empowerment (Resolution of the Council of Ministers n. 101/2015). The Programme is currently financing 88 social inclusion projects throughout the country and has, over the years, financed 532 projects, which involved 3493 institutions in total, 2920 facilitators, and benefited nearly 300,000 people (Programme Escolhas, 2014). The projects are planned and run locally, through local institutions, namely local authorities, schools, training centers, local commissions for the protection of children and young people at risk, sport and juvenile associations, and private enterprises, based on strong partnership among the institutions within each community (Resolution of the Council of Ministers 101/2015).

Families are viewed as key partners and considered indirect participants in all projects, with several of the actions developed aiming at fostering parental involvement at schools, favouring stronger connections between parents and children and more positive expectations from the parents in relation to their children's future (Matos et al., 2014). The projects are tailored to the specific youth and community's needs, and the programs are developed for three years, through strategic planning and a set of objectives and indicators that are self-assessed regularly. Some of the projects directly target parents, and implement several tailored activities to increase their parenting skills and overall involvement in their children's education, namely through group sessions for parents, family-school mediation activities, and community-based activities. Overall, and based on the self-assessment of the institutions involved and the promoting entity, the programme has reached good results and it has been considered a good practice for school integration and social inclusion, given its success in engaging children and

youth in schools, or integrating them in vocational training programs and in the labour market. Its innovative character based on strong partnership, the commitment to promoting digital inclusion, and its efficiency in the use and management of resources have been also highlighted (Matos et al., 2014).

Early intervention

There is also a National System of Early Intervention (SNIPI) service that includes a set of preventive and rehabilitation measures designed to support children aged between 0 and 6 years, with disabilities or at risk, and their families. This provision includes innovative features in the Portuguese context, namely, the interagency network of resources, based on the intersectorial coordination of education, health, and social security services that operate at the local, regional, and national levels. The service in 2012 included (a) a national coordination committee consisting of two delegates from each ministry (Education; Solidarity and Social Security; and Health) and chaired by a delegate from the Ministry of Solidarity and Social Security, (b) five regional subcommittees, and (c) 149 local intervention teams (Pinto et al, 2012). Local intervention teams are interdisciplinary (including general practitioners, psychologists, specialized educators and therapists), and their work is framed by a family-centred approach, in which families' diverse needs and resources are addressed and valued, as well as those existing in the community. Family is thus actively involved in the decision-making process. The service is also characterized by a prevention focus, targeting children at risk. Eligibility criteria include limitations in body functions or body structures that limit children's normal development and participation in typical activities, taking into consideration their age and social context, but also risk factors related to biological, psycho-emotional, or environmental conditions, including family stressors and environmental risk factors, such as poverty, low education. The service is free of charge for parents.

2.2.7.3 Monitoring

Monitoring of parenting support services has been mainly conducted by academic institutions. The first nationwide study aimed at identifying the variety of ongoing parenting interventions was undertaken in 2009, and it was developed through a collaborative protocol between the Commission for the Protection of Children and Adolescents at Risk, the Institute of Social Security, and a network of five public universities (Abreu-Lima et al, 2010; Almeida et al., 2012). The study intended to provide empirical data to inform policy making on child protection and family policies. At that time, 68 parental education interventions were identified and evaluated (Abreu-Lima et al., 2010). The results suggested that participation in parenting interventions was associated with an improvement in parenting practices, higher levels of perceived social support, and a reduction in parental stress. However, further analyses showing that parents with higher educational levels benefited more from the interventions than parents with low education, raised the issue of equity of the programme (Almeida et al., 2012). At the present, an ongoing nationwide study is being conducted by the University of Porto, in collaboration with other universities (Cruz, 2017). This study has identified more than 200 actions across several education and social agencies, although the vast majority referred to single seminars or workshops and only a very few used a systemic, standardized approach, with clear identified goals and activities framed in a theoretical model.

At the governmental level, there are several bodies responsible for the supervision and monitoring within each sector. In general, these mechanisms tackle the access and number of services in each sector, whereas monitoring of quality, effectiveness or equity is less common or inexistent. In the health sector, the Health Regulatory Authority is an independent public entity responsible for assessing the activity and quality of health care settings, through a set of indicators (Decreto-Lei 126/2014). In regard to the social sector, the Planning and Strategic Office (Gabinete de Estratégia e Planeamento) provides general statistics and annual reports on the number and evolution of the social services across the country (GEP/MTSSS). However, the office does not monitor the quality of services. For quality, the Social Security institution issued in 2005 two documents that provide a quality model, based on the European Foundation for Quality Management. These documents are very extensive and include several themes related to access, admission, and quality of the services. Institutions are expected to conduct their own quality assessment, through self-reports. In case of complaints or when deviations from the guidelines are suspected, the Social Security Institute is responsible for making inspection visits to the private institutions. In 2015, 281 inspection actions were conducted to crèches. In regard to education, the General Inspectorate for Education commissioned by the Ministry of Education supervises and assesses the quality of the entire network through regular inspections. It is important to note that the Inspectorate assesses the quality of services not only in the public sector, but also in regard to private education institutions and thus, the same set of quality criteria apply to all educational contexts and regions. Annual reports containing information about the activities and their quality are provided. In 2017, the inspectorate covered nearly 80 school clusters, within a universe of nearly 800.

Nevertheless, at present there is no specific governmental body that oversees family protection policies and their impact (Wall, 2014). Similarly, publicly subsidized programs are rarely evaluated in terms of effectiveness or tackling equality issues. Rather, information on family and equality issues is scatter, incomplete and fragmented. There are independent scientific labs, namely the Observatory of Family and Family Policies (Observatório das Famílias e das Políticas de Família; OFAP), which examines family issues and policies in the national context, as well as the Observatory of Inequalities (Observatório das Desigualdades), that examines social inequalities in Portugal and that, from time to time, provide relevant information on this topic.

2.2.7.4 Language

The High Commission for Migration (ACM) has launched a program, the Portuguese for All, that makes available to the immigrant population certified Portuguese courses at the level that is necessary to get access to nationality, permanent residence and/ or status of long run resident. The courses aim to promote the social and professional inclusion of immigrants, strengthen the conditions for citizenship exercise and provide greater equality of opportunities for all. The courses are free of charge for participants and are provided at schools, centres of employment and professional training and universities. An electronic platform with pedagogical resources aiming to teach the Portuguese language to foreigners is also available at the ACM website. ACM also provides a service of translation through telephone.

2.2.7.5 Main challenges

While some services, such as Early Intervention, adopt a family-based approach, public support

to families in Portugal is low. Parenting support is mainly provided on a voluntary basis and through ad hoc initiatives. The current services that do provide parenting support, such as Family Support and Parental Counselling Centres and *Social Integration Income*, do not have a universal scope. In addition, there is a lack of guidelines for these services, and therefore the type, intensity, quality or duration of interventions are likely to vary from service to service. Even though Portugal has a child-friendly legislation, “there is a clear gap between the way laws and even policies are designed and launched, their actual implementation, and the practices developing from such laws and policies” (Perista, 2014, p. 14). Family support has not been consolidated into a concrete comprehensive national strategy able to oversee family support policies and practices. Similarly, there is no overall strategy for tackling child poverty and social exclusion in Portugal. “Addressing child poverty and social inclusion and breaking the cycle of disadvantage will only be achieved by a coherent, continued and long-term approach centred on the actual needs of children and their families” (Perista, 2014, p. 8).

Social policy in Portugal is fragmented, marked by discontinuity rather than strategic continuity in policies, and a strong delegation of state responsibilities in private institutions, without adequate monitoring and supervision.

The economic crisis led to several changes regarding social protection to families, including the reduction of economic support for all families, but also for very low income families. Even though the current government has started to invert some of the measures, by changing the eligibility criteria, most of social protection measures after the economic crisis persist, with fewer families receiving support at the various levels. In addition, regarding crèches, changes in regulations for group size that have increased the number of children per classroom are still in force, raising the issue of whether these changes are being conducted at the expense of the quality of services. Indeed, in one recent study conducted in Porto, involving 90 classrooms, it was found that larger group sizes were negatively related to the quality of infants’ relational experiences (Barros, Cadima, et al. 2016).

As stated, “Overall, Portugal’s efforts to keep up its high standards as regards formal compliance towards international responsibilities regarding children should be matched by equally high standards as regards actual implementation of those commitments.” (Perista, 2014, p. 15).

2.3. CONCLUDING REMARKS

In this section, the description of parenting and family approaches was placed in the context of an overview about each country's family policy and service frameworks. Below, we highlight some important contextual conditions that can elucidate about key features of parenting support programme implementation, as well as current challenges that countries are facing.

Countries show different approaches to family and parenting support

Even though it is visible in all countries that family support encompasses a broad range of services that cross several sectors, there are important variations across countries.

The main cross-country differences are related to both the core approach in relation to the support of parenting and the extent to which parenting support is integrated in a clear policy framework. In England, Germany, the Netherlands, and Norway, parenting support has been incorporated into national comprehensive early intervention strategies. In these countries, parenting support is part of a clear strategic framework that integrates a broad range of early intervention and prevention services for parents and families. These countries also share a trend towards more integrated approaches to child and family services through collaborative working of education, health and social services.

England's *Children centres*, Germany's *Family centres (Familienzentren)*, Netherlands' *Centres for Youth and Family* and Norway's *Health Clinics* are examples of centres that provide a broad array of initiatives and activities to parents and children, sometimes combining early childhood education and care for children, health care and parenting support. These centres are also characterized by providing highly accessible low-threshold services, in which different forms of parenting support are offered, ranging from preventive and open access services to more structured and specialised support. Although all mentioned countries offer such integrated centres, the countries differ in how widespread these centres have been implemented. For example, in Germany only some federal states have fostered the implementation of family centres widely.

England, Germany, the Netherlands, and Norway, appear to share a trend towards more holistic approaches for young children and their parents (Boddy et al., 2009), with an emphasis on early preventive intervention and greater state engagement with parents (Daly, 2013). Following a strong preventive orientation, services seem to favour a continuum of care, incorporating parenting support into a range of services and actions that provide parents resources and support mechanisms that will help them in their children's rearing.

While program-specific features will be later discussed in this report, in an attempt to identify key characteristics at the levels of programme implementation and strategic service coordination, some of the features described in the (four) country profiles are considered key elements of effective parenting support in the literature:

1. **Multifaceted interventions** (Brooks et al., 2000; Dunst & Trivette, 2009; Evangelou, 2011; Moran et al., 2004): it has been suggested that services that address more than one area of need and involve both parents and children are more likely to succeed. The recent early intervention and parenting approaches in the four countries seem in line with this.

2. **Easily accessible services** (Moran et al., 2004): as observed by Moran et al. (2004), directly accessible support is a key element of parenting support; in the four countries, there are several examples of low-threshold services locally available. In addition, easy access to support may facilitate inclusion and prevent stigmatisation.
3. **Integrated approach to services** (Molinuevo et al., 2013): as described, there seems to be a trend towards service coordination and multi-agency collaboration, favoring a better continuity between universal and targeted or specialist provision.
4. **Wide range of parenting support services** (Moran et al., 2004): making available a variety of parenting support services increases the likelihood for parents to find the support that better addresses their specific needs.

One aspect worth noting is that the recent trends towards easily accessible services and integrated approaches are seen in countries that vary greatly in terms of levels of governance and service organization (from highly centralized at the national level to highly decentralized and organised at the local level), targeting approaches (group-based vs. area-based), and the ways through which universal and targeted provision are linked. In relation to the latter, it appears that the potential tension between universal and targeted approaches has been somewhat attenuated in the mentioned countries. From an equity perspective, even though previous literature has called attention to the fact that the distinction between universal and target provision is nuanced and often blurred (Boddy et al., 2009; Molinuevo et al, 2013), there is great discussion over which type of approach brings more equity to the system: on one hand, universal approaches offer support to all, but may offer less to those who need the most; on the other hand, targeted approaches may provide more for those who need the most, but can (i) stigmatize and (ii) miss families in need, given that they do not meet the targeting criteria. It seems that easing the access through low-threshold services in which integrated forms of parenting support are offered through coordinated support services and networks favours a continuum from universal to target approaches, offering a comprehensive support to families.

Challenges in equal access to quality provision

Nevertheless, across countries, several challenges remain, in particular in regard to equal access to high quality provision. While there are several benefits of local support, including tailored provision according to local needs, and partnership building with and between several agencies and local communities, there is a risk of a lack of a coherent strategy. Coordination mechanisms and cooperation among key actors with clearly assigned roles and responsibilities are key aspects to prevent service fragmentation. Similarly, services need to be monitored not only in regard to whether they are addressing the local needs, but also in regard to their connections to other services. Local services may be unique in facilitating community capacity building and strengthening existing sources of support (Dunst & Trivette, 2009). Community active participation and engagement in the services may facilitate greater use of resources, as well as clear identification of local resources and needs. However, the balance between a focus on community engagement and on quality assurance can be hard to achieve. Local support can also lead to different quality standards across localities as it can be difficult to ensure transversal high-quality services, which may cause inequality issues at the regional level. Ensuring equal access to quality not only requires high-skilled staff (as will be discussed in more detail in the subsequent section), but also that differences across regions are tackled,

which requires monitoring schemes across local, regional, and national levels. However, as it has been pointed out in many country profiles, there is still limited monitoring.

A second main challenge reported by several countries relates to reaching particular groups of parents, namely parents with a migrant or ethnic minority background. Even when the services target these groups, the most migrant or ethnic minority families tend to use services less than the average. This particular challenge and the strategies used to tackle it are systematized and discussed in the next section of the present report.

In the Czech Republic and Portugal, and up to a certain extent in Poland, particularly for children under 3, parenting support is far less developed compared to the other above-mentioned countries. The main approach taken in parenting support is focused on the most vulnerable families through targeted specialist support, whereby families must be identified as meeting certain criteria to get access to the services. Families, rather than parents, are the main focus of services and services—that are, in essence, support provision to address the most basic needs—are oriented towards child protection and towards families in adverse social circumstances.

Even though direct support to parents is still not part of a holistic early intervention strategy, local and small-scale initiatives do exist. In Poland several voluntary-based initiatives designed to support parents in their parenting task have been putted into place, including large-scale information campaigns. Even in Portugal, in which family policy approach has been characterized by discontinuity of policies and service fragmentation, a number of cross-sector, family-centred approaches can be identified. Of note is that these three countries show small rates of immigrants and foreign-born people. At the same time, the relative income gap between median income and that of the bottom 10 per cent of households with children is larger in the three countries, when compared to the other participating countries. An additional number of challenges is reported by these three countries, namely restrictive eligibility criteria for accessing services, leaving many families in need out of support and lack or limited access of parenting support in general, and limited supervision and monitoring.

Health-related parenting support

A short but worth noting trend is that in most participating countries, other sectors than social/welfare, which is mainly in contact with vulnerable families, have been involved in parenting support services, highlighting the preventive focus of these services provision. In particular, all countries include a family support dimension within health services. Health professionals are often well-known and trusted by families; in addition, they are often in touch with the families before the birth of the children. As a consequence, countries have seen the broadening of the scope of health services through the inclusion of family and educational support.

Wider family support measures

With regard to the relationship between leave policy and ECEC policy, countries show differing priorities and approaches (Eurydice & Eurostat, 2014). For children under three, some countries, such as Czech Republic and Poland, encourage parents to look after their children through long parental leaves, and offer limited ECEC provision for this age group. Other countries, such as Portugal, favour an institutional approach to childcare, which translates into

more investment in ECEC provision and higher enrolment rates. Other countries, more noticeably Norway, provide strong state support for parents, through long paid parental leaves and well-developed services for children aged under three. What it is interesting to note is that the countries that provide a wide range of parenting support services show varying approaches to both parental leave and ECEC. For example, the Netherlands and England (UK) share comparatively high costs for ECEC attendance (for children under 3 years) and low rates of full time attendance, although part time attendance in the Netherlands is the highest amongst the 7 countries. In contrast, Germany has considerably longer leave periods than the Netherlands and England.

Still, it is important to mention that there have been recent changes in ECEC provision in several countries. For example, there have been increases in the implementation of provision in recent years, namely in Germany, which has extended ECEC for children age 1 and over. However, other recent changes in ECEC systems raise new equity challenges, namely in the Netherlands, through expansion of the market and the increased likelihood of unequal access to high quality, and in Portugal, through changes in important structural quality criteria that can lower overall levels of quality. Also, it should be mentioned that although disadvantaged children are given priority or free access to ECEC in some countries, equal access remains an unsolved issue in almost all countries.

A final note regards after-school care, as it can be noted in country reports that after-school programmes are not regulated in terms of access or quality provision, which can raise inequality issues. In this particular issue, Portugal stands out, regulating and providing universal after-school care for children aged 3-5.

Language support

A key question to ISOTIS is the extent to which programmes of parenting and family support include families' cultural and linguistic resources. Countries describe a variety of actions aiming at providing language support for parents and children. Language support can take different forms, including, for example, interpretation and translation services that enable parents to access services and communicate with staff, or translated materials in many languages. Across countries —although there are some initiatives that support heritage language— parenting programmes that take into account mother tongues are just a few. This topic is further developed in the subsequent section of this report, when discussing programme-specific key features. However, it is important to highlight the distinction between language support in parenting support services/programmes and in Early Childhood Education and Care (ECEC), since in the latter, the support offered to children's language learning is more systematic and sustained. To be sure, within ECEC system, several countries do include explicit language support policies that address both country and home languages, although varying in degree and nature: for example, courses or additional/compensatory programmes for non- or poor country language(s) speakers seem to be more common than more intensive and embedded support policies that *entitle* "national ethnic minorities or communities using regional language" to actively "support minority children's language acquisition and their cultural, historical and ethnic or national identity", as referred in Poland's country profile.

3. CHARACTERIZING PARENTING/FAMILY SUPPORT SERVICES/PROGRAMMES ACROSS THE 7 EUROPEAN COUNTRIES: KEY FEATURES AND PRINCIPLES TO TACKLE EDUCATIONAL INEQUALITIES

Gil Nata, Joana Cadima, & Yvonne Anders

As referred in the ISOTIS project proposition, Task 3.2 “will collect evidence on programme evaluations for the target groups of ISOTIS and similar groups, using various search strategies (including scholar databases, internet/google search, reports of ISOTIS partners, and expert consultation). The inventory will include grey and unpublished literature of the participating countries and will concentrate on any evidence of particular new and innovative approaches in a comparative way. (...) Questions concern delivery modes, the requirements of effective and inclusive approaches, the role of ICT to help improve family support systems, especially for bilingual families, the effects monetary reward systems for reach out and the experiences with combining family-focused approaches with centre-based programs”.

Bearing in mind the overarching goal of the ISOTIS — tackling or diminishing educational inequalities — this report will try to add to the existing body of knowledge in several ways. In fact, as seen in the state of the art summary (in the introductory section), existing literature reviews and meta-analysis about parenting support do generally report gains in parents, children, or both, that were under intervention (in comparison with those that were not). Nevertheless, it is important to notice an apparently subtle but important distinction: an effective intervention (i.e., that has produced an overall gain) does not necessarily guarantee that existing divides between those that are most in need and others were tackled (if not widened).

Consequently, this inventory will start to add to the state of the art by devoting particular attention to this issue, focusing, on the one hand, on what the data tell us about the narrowing of the educational gaps (either by synthesizing the information available, either by registering its absence), as well as, on the other hand, the evidence of the intervention’s success relating to groups that are generally highly disadvantage, i.e., immigrants/non-native speakers, ethnic minorities, and low income/at general social risk.

Additionally, taking advantage of the ISOTIS consortium potential and resorting to the 7 partners/countries expertise within the field, grey literature was reviewed and promising services/programmes were identified by each country’s experts and taking into account its’ respective context.

Finally, the particular focus of this task in the potential of ICT components and bilingualism also addresses important challenges of today’s European societies and differentiate this inventory from existing literature reviews.

With this in mind, an important distinction was made: first, we wanted to collect existing evidence on what works supporting good parenting practices, especially for the ISOTIS target groups and bearing in mind ISOTIS objectives; second, we also wanted to gather information on existing services/programmes that have not been thoroughly evaluated, but might give powerful insights to promising practices, namely when each country specific context is taken into account. Therefore, an overarching distinction between evidence-based and promising was drawn. Evidence-based are services or programmes that have been subjected to high-standard

evaluations with demanding study designs, namely RCTs or Quasi-experimental studies (including matched comparison group designs, single-case designs, and regression discontinuity designs). Each country's expert(s) could consider a programme or service promising for different reasons, namely:

- A programme/service that might have established evidence that is unpublished or is published in grey literature;
- A programme/service that can be promising because of its innovative character, although it has not yet been evaluated through high quality studies. In this context, innovative means new or unusual, in a given context. Therefore, a programme or service can be non-innovative in a context, but innovative a different context. Innovative can mean that it questions and challenges the status quo. It is not necessary for a programme or service to be considered innovative to have established effectiveness, given that the newness of the nature of innovative can also imply that it is still untested. Nevertheless, there needs to be reasons to believe that it will be successful if tested, for example, because of its strong programme design.
- Although innovative is frequently associated with novel (in the sense of newness), it can be the case that a service or programme can be considered innovative despite the fact that it exists for some time; again, the main issue revolves around being unusual within a context.
- A programme/service that is highly considered among academics and/or personnel and/or communities, although it has not yet been evaluated through high quality studies;
- A programme/service that is able to reach “hard to reach” groups;
- A programme/service that is “in place” for a very long time integrated into the network of community resources, but hasn't had enough (if any) evaluations;
- A programme/service that attempts to address a particular challenge of a specific country or context;
- A programme/service for which there are high quality studies (that establish their effectiveness) conducted in a different country than the one where it is being implemented (and reviewed).

A manual was developed that detailed the search protocol to be followed by each partner involved in this task, as well as the inclusion criteria (Annex 1).

3.1. SEARCH PROTOCOL

Partners involved followed a common search protocol. This protocol implied contacting or searching each one of the following categories of resources: (1) Stakeholders/experts; (2) University Databases; (3) National Specialized journals; (4) Governmental websites or publications; (5) Non-governmental websites or publications; (6) Search Engines; (7) Online databases.

A search strategy for searching databases was devised and a correspondent list of keywords and search terms was indicated to all partners (for more information on these, consult the Manual “WP3 Inventory and analysis in parenting- and family-focused support”).

All partners needed to detail the list of stakeholders/experts and resources consulted and

within each, list the number of services/programmes initially identified. Finally, partners had to select and identify the number of interventions/studies eligible according to the inclusion criteria.

In the case of too many programmes being identified (i.e., above 15¹⁸), additional auxiliary criteria was established to narrow the selection. Specifically, partners ought to prioritise services/programmes according to a subset of three criteria:

- Existence of an ICT component, justified by the particular focus of the ISOTIS project on developing a Virtual Learning Environment for (amongst others) parents;
- Focus on home language support, since one of the ISOTIS goals is the promotion and valorisation of the home language, particularly (ISOTIS) minorities' languages;
- Potential to reach “hard-to-reach” groups, given that ISOTIS focuses on tackling educational inequalities, which subsumes the challenge to get to most vulnerable and “hard-to-reach” groups.

Additionally, if after the application of the previous criteria, an excess of services/programmes still remained, partners should resort to the following subset: (i) Services/programmes that are on-going should be given preference to programmes that have finished or are not currently running; (ii) Services/programmes that have a wider coverage (namely in terms of the ISOTIS target groups); (iii) Services/programmes that have a higher level of social acceptance by the community.

3.2. INCLUSION CRITERIA

In addition to the search protocol, inclusion criteria were devised to guarantee the coherence of the selected services/programmes for this inventory amongst themselves, between countries, and with the ISOTIS goals and target groups. Inclusion criteria included was operationalized through PICO's model (see below).

Age range: Services/Programmes should necessarily include parents with children within the following age range: prenatal until 10/12. A service that goes beyond 10/12 years old can be included as long as children below this age are also participants.

We are interested in **evidence-based or promising** programmes/services. There are two paths for the inclusion of evaluations of the parenting/family programmes/services.

- 1) The first option is to include a programme/service that is evidence-based. The programme has been subjected by high-standard studies with demanding study designs, namely RCTs or Quasi-experimental studies (for more detail, please see PICOS' study design criteria).
- 2) Additionally, and given that one of the ISOTIS objectives is to select innovative and promising interventions, it is possible (even desirable) for partners to include other programmes/services under the heading of “promising”. This option is intended to take advantage of the expert knowledge of each partner in order to include programmes or services that may be considered promising but for which there aren't (still) any RCTs or Quasi-experimental evaluation studies. Therefore, the inclusion of “promising” studies implies a subjective assessment by the expert/partner (please see the “promising” and “innovative” definitions for more

¹⁸ The upper threshold of 15 services/programmes (and a maximum of 3 studies per programme) was decided taking into account the available resources for this particular task.

detail). This is reflected in the information retrieval/assessment grid, with the request for partners to justify the reasons for considering a service or programme as “promising”, information that is unnecessary whenever the selected study is labelled as evidence-based.

(PICOS’) Inclusion Criteria:

- **Population:** Parents of children under 10/12 years-olds (until the end of primary school, which varies across countries), including parents-to-be. There has to be data on one or more of the ISOTIS target groups (Roma, Immigrant background/non-native speakers, Low-income/general social risk). “Universal” services or programmes (i.e., services or programmes directed to the general population) can be included as long as outcome data on one or more of the 3 general ISOTIS target groups is provided. Exclusion criteria: studies that do not include outcome data on one or more of the target groups; that focus exclusively on children (and not on parents); that focus on parents of children with more than 10/12 years; programmes that target on the basis of signs of child development problems or family problems (e.g., neglect; child abuse); programmes that target individual children on the basis of detectable signs or symptoms in development (e.g., risk of conduct disorder); programmes that target children identified as currently suffering from a recognisable disorder (i.e. ‘treatment’).
- **Intervention (programme/service):** The service/programme has to be primarily a parenting/family support service or programme or the use/attendance of such services. Services/programmes that are ongoing (independently on when they were developed or the initial date of implementation) or have been set up within the last 10 years. Exclusion criteria: programmes that focus primarily on other dimensions, such as anti-obesity programmes or post-natal depression programmes. Service/programmes that have been set up more than 10 years ago and are not ongoing.
- **Comparison:** comparison group can be no treatment or a reference treatment (“treatment as usual”). Single-case designs do not require a comparison group. In the case of studies that are selected under the “promising” criteria, it is not necessary to have a comparison group.
- **Outcomes:** any outcome that fits the definition of a parenting/family support service or programmes (e.g. Quality of learning home environment; Parental sensitivity and attachment, Socio-emotional development, Language and communication; Knowledge and use of resources and support services available, for example ECEC attendance); Engagement in social networks and community; Child development and school readiness, Emotional and behavioural development). Exclusion criteria: Any study that does not include as a measured outcome variables that are related to parenting/family support.
- **Study design:** RCTs and Quasi-experimental studies (incl. matched comparison group designs, single-case designs, and regression discontinuity designs) are eligible. Other study designs may be included under the “promising” heading. When this is the case, the partner should provide the reasons for the “promising” label. Exclusion criteria: studies that are not RCTs or Quasi-experimental studies and that partners do not consider “promising”.

3.3. ANALYSIS

Entries on the inventory were made by service/programme, and each service's/programme's information was entered according to the following predefined set of boxes (organized into sections), which constitute in itself a first level of content analysis (asterisks indicate mandatory boxes; for further information on the boxes contents, refer to the Manual "WP3 Inventory and analysis in parenting- and family-focused support"):

- Selection Criteria (for the programme/service): Level of evidence*; Target group*;
- General Information: Country*; Service/Programme*; Authors*; Type of Authors*; Level of implementation, Sector & agency*; Destinataries' eligibility and recruitment criteria*; Age group*; Years in operation*;
- Characteristics Of The Programme/Service: Goal(s)*; Theoretical framework; Locale*; What does the service/programme consists on (what is done, activities, etc.)*; Dosage and Duration; Types of resources & materials; Staff requirements; Staff guidelines; Parents/Target groups as staff/actors; Improving access to other services; Use of ICT; Role of heritage language; Language support Evaluation;
- Study(ies) Or Evaluations About The Programme/Service (one entry by reference): Reference* | Source | Link; Year of implementation; Study goal(s)*; Outcome variables*; Study Design*; Sample size; Main results*;
- Expert Evaluation (your own opinion): How innovative is the service/programme; Target groups' needs; Outreach and participation; ICT; Evaluation/outcomes of programmes; Programme implementation; Transferability: Implementation elsewhere; Established evidence in other countries/contexts; Other/Observations.

The content within each service/programmes boxes were further subjected to qualitative thematic content analysis (Burnard, 1991; Ezzy, 2002), in search for emergent themes. This implied several readings of the material in several ways, in accordance to the objectives of the analysis: a first reading of each service/programme as a unit was made, in order to gain familiarity with each service/programme's coherence; all of the country's selected services/programmes were also extensively read with the objective to try to find emergent themes within each country; nevertheless, the bulk of the analysis was done within major categories of interest (e.g., boxes that contained information on the reasons as why programmes were selected as promising) across countries, in order to find within these themes, common and/or contrasting features. Thus, besides the categories that were already established in the retrieval grid that was sent out to partners, the categories and themes were not established a priori, but rather through a back and forth analytical process. The analysis was done through the use of NVivo 11 software.

3.4. IDENTIFIED AND INCLUDED SERVICES/PROGRAMMES

There were very contrasting scenarios in relation to the programmes identified by the different countries, either as to the quantity of identified services/programmes, either to the quality of the empirical evidence available, as it may be seen in the table below.

Table 1. List of services/programmes in each country

# TOTAL	# Evidence-Based	# Promising
Czech Republic		
2	0	2
England		
17	11	6
Germany		
12	7	5
Netherlands		
8	6	2
Norway		
6	2	4
Poland		
2	0	2
Portugal		
11	4	7

As described above, two main criteria were used to include services/programmes in the inventory: (i) evidence-based, when services/programmes have been assessed through high-quality studies, and (ii) promising, which was based on assessment by country experts.

3.4.1 LIST OF PROGRAMMES IDENTIFIED AS EVIDENCE-BASED

Table 2 presents the list of services/programmes that have been identified through the evidence-based criterion in each country and some of its key characteristics.

Table 2. List of services/programmes identified as evidence-based

Evidence-based Programmes	Level of implementation	Sector	Universal vs. Targeted	Target group	Integration with other services
Czech Republic					
Non-identified					
England					
Parent Early Education Partnership (PEEP)	National	Education	Universal	Low-income Families	Non-specified
Home-Start	Local	Health & Education	Targeted	"Struggling" families with at least one child under 5	Home-visitor helps family access health, housing, mental health, financial, and children's centre-based services
Early Words Together (EWT)	Local	Education	Universal	Families with children in ECEC	Improves children's school readiness for primary school
Life start Parental Programme	Regional	Not specified	Universal + Targeted	Offered to all parents	Non-specified
Families and Schools Together (FAST)	Local	Education Health & Welfare	Universal	Socially disadvantaged and low-income families	Non-specified
Making it REAL	8 local authorities	Education	Targeted	Disadvantaged children: needing greater support or family being disadvantaged	The programme can make families aware of additional needs their child may have and inform the family of services they can use to address those needs.
The Raising Early Achievement in Literacy	National	Education	Targeted	Low income and socially disadvantaged	Non-specified

				families	
Parents as First Teachers (PAFT)	National	Education	Targeted	Low income and socially disadvantaged families	Non-specified
Family-Nurse Partnership	National	Education & Health	Targeted	Vulnerable first-time teenage mothers and their children	Non-specified
Bookstart Educational Programme	National	Education	Universal	Socially and economically disadvantaged families	Non-specified
Parents and Children Together (PACT)	National	Education	Universal	Offered to all parents	Non-specified
Germany					
Chancenreich	Local	Not specified	Universal	Low-income	Non-specified
Pro Kind	Local	Welfare and health	Targeted	Low-income prenatal mothers	Early warning system
Eltern AG	National	Welfare	Targeted	Low-income and single-parent households	Non-specified
STEEP - Germany	Local	Not specified	Targeted	Mothers with a high risk of abuse, low-income	Non-specified
Keiner fällt durchs Netz ["Nobody Slips Through The Net"]	11 states in Germany	Not specified	No specific target group	Families at risk (low education, poverty, violence in families)	Non-specified
Guter Start ins Leben	South of Germany	Welfare	Universal	No specific target group from pregnancy to 3 years	Non-specified
Opstapje	Local	Welfare	Targeted	Low-income parents, parents with low level of education, parents who are hard to reach outside their homes regarding child care provisions	Non-specified
Netherlands					
Opstap [Step Up for kindergartners]	National	Education, Welfare and Health	Targeted	Disadvantaged pupils from low-educated families (Based on weighing rules)	ECEC
Instapje [Step In]	National	Education, Welfare and Health	Targeted	Disadvantaged pupils from low-educated families (Based on weighing rules)	Parents are encouraged to sign their child up for ECEC
Boekstart/Boeken pret [Bookstart/Fun with Books]	National	Education	Universal + Targeted	Low-literate and, consequently, also low-educated families (both native and immigrant parents) who lack attention to reading	The goal is to activate parents to go to the library more often
Incredible years [In Dutch: Pittige Jaren]	National	Education, Welfare and	Targeted	Parents with children between the age of 3-6 who have severe	Non-specified

		Health		behavioural problems or deficits	
Home-Start	National	Education, Welfare and Health	Targeted	Parents with a child in the age of 0 to 6, who are in need of support	The goal is to stimulate the parent to interact with the community and networks around the family, such as libraries, schools and other.
Reading Express [Voorleesexpres]	National	Education	Targeted	Parents of children that have a possible language delay and/or who have a poor language environment at home (often immigrant parents and/or socio-economically disadvantaged)	The programme stimulates the use of the library.
Norway					
The Incredible Years [De Utrolige Årene]	National	Health	Universal	Parents of children with risk of developing, and developed conduct disorder.	Referral from nurses at health clinics based on perceived need or recommended from ECEC.
Early Intervention for Children at Risk [Tidlig innsats for barn i risiko]	National	Health	Universal	Parents of children with risk of developing, and developed conduct disorder	Referral from communal services (health clinics, welfare, school) based on perceived need.
Poland					
Non-identified					
Portugal					
Playgroups for Inclusion or "Grupos Aprender, Brincar, Crescer" (GABC, Groups where children Learn, Play and Grow)	National	Education	Universal	Children not participating in any of the currently available ECEC services in Portugal	Non-specified
Incredible Years for Parents	Local	Education & Health	Universal	Multiple initiatives with different target groups	Non-specified
Triple P - Positive Parenting Programme - Level 4	Local	Education & Welfare	Targeted	Low-income.	Non-specified
A Par programme - an adaptation of UK's (Oxford) Parents Early Education Partnership (PEEP) programme	Regional	Education	Universal	Children not participating in any of the currently available ECEC services in Portugal	Non-specified

3.4.2. LIST OF PROGRAMMES IDENTIFIED AS PROMISING

Table 3 presents the list of services/programmes that have been identified through the promising criterion in each country and some of its key characteristics.

Table 3. List of services/programmes identified as promising

Promising Programmes	Level of implementation	Sector	Universal vs. Targeted	Target group	Integration with other services
Czech Republic					
Housing First for Families in Brno	Municipal	Education & Welfare	Targeted	Roma and low-income	Non-specified
Social activation services for families with children	Regional	Welfare	Targeted	Roma and low-income	Non-specified
England					
EasyPeasy	Local	Education	Universal	Open-access for families with children in ECEC	Non-specified
Let's Play in Tandem	Local	Education	Targeted	Low income and socially disadvantaged families	Home visitors may encourage parents to take their child to the library, community play groups and to continue the activities after the weekly visit is over.
Empowering Parents, Empowering Communities (EPEC)	Local	Education & Health	Targeted	Low income and socially disadvantaged families with a child who is showing behavioural problems	Non-specified
Parents 1st community parent volunteer peer support	Local	Health	Targeted	Low income and socially disadvantaged families	Non-specified
Strengthening Families, Strengthening Communities	National	Education & Health	Universal	Offered to all parents	Non-specified
Family Skills	National	Education	Targeted	Parents/carers of reception children with English as an additional language (EAL)	Parent-school partnership
Germany					
Stadtteilmütter	Local	Welfare	Targeted	Mothers with Turkish or Arabic background - whose children don't visit preschool because of language problems or other difficulties	A main goal is to get families to enrol their child into ECEC.
Wir2 (before PALME)	Local	Welfare	Targeted	Single-parents	Non-specified
Griffbereit	Local	Not specified	Targeted	Mothers with migrant background	Non-specified
Rucksack	Local	Education	Targeted	Migrant background	Non-specified
FIT - Migration - Bremen	Local	Not specified	Targeted	Migrant background	Non-specified
Netherlands					
Opstapje [Step Up for toddlers]	National	Education, Welfare and Health	Targeted	Disadvantaged pupils from low-educated families (Based on weighing rules)	ECEC
VVE Thuis [ECEC at home] ¹⁹	National	Education, Welfare and	Targeted	Disadvantaged pupils from low-educated families	ECEC

¹⁹ A quasi-experimental study has taken place in 2016, but no results are available yet.

		Health	(Based on weighing rules)			
Norway						
ICDP: International Child Development Program	National	Education & Health	Targeted	Immigrant families/imprisoned parents/parents of children with special needs	Non-specified	
Health Clinics	National	Education & Health	Universal	Universal access	The health clinics may refer parents to other programs	
Circle of Security [COS-P]	National	Education & Health	Universal	Universal access	Non-specified	
Open Access Kindergarten [Åpen Barnehage]	National	Health	Universal	Universal access	A prime goal is to promote participation in ECEC	
Poland						
Dobry Rodzic - Dobry Start (Good Parent - Good Start)	Local	Health & Welfare	Universal	All parents with children under the age of 6	Workshops preparing parents and children for pre-school, school	
Family assistant	National	Welfare	Target	Families who, due to negative bio-socio-cultural factors, including low SES, have problems with fulfilling their family and social roles	One of the goals of the service is to enable / facilitate access to different family services (health, law, education)	
Portugal						
«Travelling Preschool Education - Below and Beyond Glass Rooms»	Local	Education	Targeted	Roma children and their families	Non-specified	
Municipal Parental Education programme	Regional	Education & Welfare	Universal	Universal access	Non-specified	
«Escolhe Vilar - E6G»	Local	Education & Welfare	Targeted	Low-income families and children/youth	Non-specified	
«CIGA GIRO - E6G»	Local	Education & Welfare	Targeted	Roma families and children/youth	Non-specified	
«Projeto Raiz - E6G»	Local	Education & Welfare	Targeted	Low-income families and children/youth	Non-specified	
«Tasse - E6G»	Local	Education & Welfare	Targeted	Low-income families and children/youth	Non-specified	
«ReTrocas - E6G»	Local	Education & Welfare	Targeted	Low-income families and children/youth	Non-specified	

3.5. RESULTS

Clear differences between groups of countries regarding services/programmes' existence

There seem to be important differences regarding services/programmes' existence between the countries that contributed to the present inventory. In fact, it is possible to discern two major groups (although with some differences within) from the 7 contributing countries.

On the one side, four countries (Norway, the Netherlands, England and Germany) clearly identify a number of services/programmes concretely aiming at parenting support, with a clear emphasis on a preventive and promotion focus. Nevertheless, there are also differences within this group of countries, namely regarding the implementation and integration of these services/programmes in the country's administrative system and overall coverage. In this respect, all of the services/programmes presented by Norway have national coverage and are integrated with the other family support services, being delivered through the national health system (namely through health clinics). The services/programmes identified in the Netherlands are generally implemented at the national level, although some are not present in all municipalities; additionally, services/programmes are essentially delivered through the public sector (namely the Dutch Youth Institute), although NGO's are also involved. Differently, in Germany and, more markedly, in England, services/programmes are characterized by local differentiation and diversity, with several services/programmes being delivered at a sub state level, sometimes in a constricted geographical area like a city or a school's cluster. Furthermore, it is clear the greater importance that non-governmental and voluntary sector have on the development and delivery of these programmes, more noticeably in England. It is interesting to note that the goals and nature of these programmes can considerably overlap.

On the other side, three countries (Czech Republic, Poland and Portugal) show a distinctive pattern, either by the smaller number of included services/programmes, but mainly due to their nature and aims. In fact, contrasting with measures fostering good parenting practices and promoting home learning environments' quality that are typical of the aforementioned first group of countries, the services/programmes included by these last countries have a general focus on child protection measures, with parenting and family measures being activated when problems are detected or even as a response to extreme situations (as, for example, the case of a housing programme in Czech Republic for homeless families). Czech Republic and Poland have identified two services/programmes each, one being implemented at the national level and the other at the local level. In Portugal, some programmes/services for parenting promotion/support were identified. Nevertheless, these are either small-scale implementation studies of international known programmes (e.g., Incredible Years) within a limited time frame or they are part of other ad hoc intervention programmes developed and implemented at a local level, usually in deprived urban areas, and within a 3 year time frame with no guarantee of continuity.

No clear pattern relating to theoretical frameworks of parenting support programmes

Analysis yielded a great variety of underlying theoretical frameworks for the included parenting/family support/education services/programmes. In addition to services/programmes that do not have a defined theoretical framework or are anchored in broadly defined parenting theories, one can find a wide array of informing theories, with contrasting levels of specificity: applied behaviour analysis, developmental psychology, social learning theory, network theory, group processes, attachment theory and theories regarding long-term effects from attachment styles, Social Interaction Learning Model; Piaget's theories; Vygotsky's theories, Patterson's Social learning theory and Bandura's social information theory; Bandura's theory of self-efficacy; theories on language development (broadly speaking) and emergent literacy and

reading skills; the ORIM framework (Opportunities, Recognition, Interaction, Modelling); conceptual frameworks of risk accumulation, behavioural dysregulation and social support as protective factor; Social ecological theory; Family systems theory; Social capital; Parent empowerment; Social learning principles; Bronfenbrenner's ecological systems theory; Parenting Styles Theory; Family Literacy Model and intergenerational learning in families; modelling theories; child and family behaviour therapy and applied behaviour analysis; developmental research on parenting in everyday contexts; social information-processing model; research from the field of developmental psychopathology; a public health perspective to family intervention; the self-regulatory framework; Transactional Regulation model; literature about the inclusion of Roma children in the school setting and school-family relationship processes in the specific case of Roma families.

Furthermore, some services/programmes refer that their theoretical underpinnings were driven by more practical inferences, namely recommendations from central international bodies (e.g., European Council's report about positive parental education) and/or findings of research evidence (namely in the US). Several of these programmes present eclectic theoretical frameworks, mixing several theories and or general principles of intervention and/or guiding values (e.g., parenting empowerment as a declared goal).

Transnational use of several programmes

One interesting pattern to highlight is the internationalization of some programmes and their inclusion either in the general country services/programmes, either at a local level. In effect, there are several examples of parental support programmes that have its origin in one country and that are adapted and implemented in another country. This is most evident in the Netherlands, Germany, and, to a lesser extent, Norway and England. Germany seems to be the country that has identified more "foreign" programmes, namely two programmes that have their origin in the Netherlands (Rucksack and Opstapje), two in the US (STEEP and Pro-Kind, which is based on Family-Nurse Partnership programme), and one in Turkey (FIT, which is based on Mother-Child-Education-Programme). The Netherlands has identified two UK programmes (Boekstart, based on the English Bookstart, and Home-Start) and one US programme (Incredible Years). Norway has identified two programmes with US origins, namely Incredible Years and Circle of Security. While England is the country that has included the higher number of programmes in the inventory, only two have been developed outside England, both in the US (Family-Nurse Partnership and PAFT). Although Portugal has also identified international programmes (namely Triple P and an adaptation of England's (Oxford) Parents Early Education Partnership (PEEP) program, named "A Par"), the programme has been implemented at a very small scale and within a limited time frame. Czech Republic is currently implementing at a local level (in the city of Brno) the Housing First (US) programme, although this is not an educational or parenting support programme in a strict sense. Poland has not included "international" parenting support or education programmes.

The transnational use of several programmes is a good indicator that countries are communicating and learning from each other's experiences. Nevertheless, it is important to stress a word of caution, related to the need to study the efficacy of a programme in every particular new context, even if there is good empirical evidence of that same programme's

efficacy in another context. To give a concrete example, the US empirically validated Family-Nurse Partnership (FNP) programme was found to be ineffective in experimental (RCTs) high quality studies conducted in England. Adding FNP to the usually provided health and social care offered no additional short-term benefit to the primary outcomes. Therefore, it was concluded that programme continuation was not justified on the basis of available evidence. In effect, it is important to bear in mind that a programme might work differently according to the context in which it is implemented; therefore, the functioning of a programme and its outcomes are dependent upon its relation with the context, in particular with the features and quality of the pre-existing services, as well as the specific needs and/or characteristics of its beneficiaries.

In close relation to this previous point, we have also found that countries do make adaptations, in different degrees, of imported programmes in order to articulate these with the pre-existing services and according to the specific needs of each context. While adaptations are expected and needed, they also raise issues related to implementation fidelity, likely to affect the effectiveness of the programmes. Striking a balance between treatment integrity and local adaptation is challenging. It seems clearly important for successful implementation to identify for each programme the features that cannot be changed, along with a constant monitoring.

Several ways in which home and country languages are (or not) used and valued

Support for language learning and the issues arising in culturally and linguistically diverse societies with non-native speakers is one of ISOTIS' key topics. Language barriers can affect levels of integration (Hachfeld et al., 2016; Evangelou et al., 2013). The analysis of language-related issues yielded two separate core themes. The first theme relates to language usage as instrumental, in response to the challenges that come from the necessity of delivering a service/programme to minorities with low proficiency in host country language. The second core theme relates to language learning as an explicit goal and focus of the intervention, and the value attached to both country and home languages.

Regarding the first theme, there seems to be three main approaches for the use of language as a mean to deliver a service/programme. First, a considerable number of services/programmes, as probably expected, is delivered in the country language(s) without any particular mention or forethought about non-native speakers; it is therefore assumed that the beneficiaries of the service/programme have, at least, a basic knowledge of the country's language. The second is the use of translation services to deliver the service/programme to those who do not speak the host country language. Norway seems to be a particular good example in setting the standards for the provision of translation for the parenting/family support/education services/programmes, given that all public services do foresee the provision of a translator when needed (routinely organized in advance of appointments). The use of translation as a means to deliver a service can also be seen at a local setting level or even at a programme level, by provision of translated materials (e.g., children's stories or booklets information for parents). The third approach relates to the use of members of the language minority groups that the service/programme is being delivered to. The goal of this strategy appears to be twofold: (i) increasing outreach (which will be more extensively discussed below) and (ii) surpass language difficulties, and also cultural resistances (this point is also analysed and discussed below), through delivering the programme in the home-language by peers.

The second core theme aggregates different attitudes toward language learning as a programme goal and the value attached to both country and home languages. These different attitudes can be better understood along a continuum, ranging from the absence of any reference to home-language, to the explicit valorisation of minorities' home languages. In several of the identified services/programmes aiming specifically at language and literacy development there was no mention to any issue related to home-language and/or difficulties due to poor proficiency, subsuming language is not a barrier for programme delivery. Another set of services/programmes included in the present inventory is characterized by a degree of tailoring that allows for the incorporation of recipients' (foremost parents) needs and desires. Consequently, themes related to home language (e.g., if parents should use home language or not when talking to their children) may arise when these correspond to parents concerns. It is not clear, however, how will these concerns be addressed and how the programmes frame their approach. Finally, there are still a set of services/programmes that explicitly value the minorities' home language, unambiguously promoting its use by parents when speaking/reading/playing with their children. In fact, the underlying assumption of these programmes is that a good stimulating home language environment does not hinder the development of the country's language but rather promotes it. These programmes largely coincide with the use of minorities' members as staff (first theme), but these characteristics may not to be associated in all these services.

A point worth noting is that minorities' home-language seems to be valued essentially because it does not conflict and may, in fact, concur with the learning of the country language. To be sure, although some programmes do support home language, there can —and should— be a more (within services/programmes) overt recognition of the value of bilingualism as an asset, i.e., as a benefit and strength (both at the individual and country level), and/or of the value of language (both country and home language) as a fundamental (cultural) identity component (this point is developed further under the multicultural heading).

Hard-to-reach strategies

One of the most important challenges when tackling educational inequalities is the problem of hard-to-reach groups. In effect, not reaching the most deprived and disenfranchised groups breeds, in itself, educational and social inequalities. Therefore, it is paramount to systematise and discuss the different strategies and challenges when addressing this topic, aiming at increasing outreach.

One importante strategy that several countries seem to use (more noticeably Norway) in order to reach out to particular marginalized groups is to connect infant/toddler system to the health care system. Furthermore, across the different services/programmes, there were several strategies identified. As already referred, the provision of translation for the services to be delivered seems to be an important way to surpass a language barrier and bring services closer to minorities that do not speak the country's language. The most comprehensive example of this kind of strategy (that might be considered a service in itself) is the Norway commitment to provide translation in all public services.

Another strategy is the inclusion of members of the minority that the service/programme is trying to reach as part of the staff. This inclusion can be seen in a continuum, with

responsibilities ranging from divulgence within the minority community or recruitment of other minority members to the actual delivery of the programme (e.g. Germany's Stadtteilmütter or England's Empowering Parents, Empowering Communities).

Yet another strategy is the use of universal money incentives, with parents being offered an amount of money, irrespective of their income, if they complete a predefined number of sessions (e.g., Germany's Chancenreich). This strategy seems to be yielding interesting results in what outreach is concerned: participants in the programme with an immigration background are in the same proportion as in the general society relative to participants that are highly educated .

A strategy identified in a Portuguese programme (Below and Beyond Glass Rooms) that tries to outreach severe disenfranchised minority groups — in this particular case, Roma families with severe distrust in general public services, showing clear signs of general social disaffection, namely absence of mandatory vaccination and registry of children's birth — is the use of dedicated teams that slowly start to approach the minority in their own milieu and gradually build a personal relation of trust that allows them to intervene with the children at first and later with the parents. It is important to notice that although this strategy does require a substantive investment, it might be justified if one thinks about the extreme degree of the beneficiaries' detachment from the countries' institutions.

Another way of increasing outreach, specifically when a group might show resistance about a certain service/programme (e.g., ECEC), is through increasing trust in the country's institutions by providing services/programmes that may serve as intermediate steps for the intended final objective. For example, Norway's Open Access Kindergartens —in which parents accompany their children to the kindergarten and attend specific parents' activities while children attend activities with the educational leaders, but in a "small dosage" (generally about 12 hours a week, divided on three/four days)— show preliminary encouraging results in outreaching to minorities. Another example is the provision of ICT training for young (Roma) parents in the local school setting with the objective of diminishing their mistrust in relation to schools and consequently increase parental involvement in children's schools. Self-assessment studies have yielded promising results, showing an increase in levels of parental involvement after attending these programmes.

Lastly, a general strategy used by several services/programmes is to deliver them in facilities that are deliberately situated in geographical areas with a large concentration of minority groups, and at convenient, easy access locales for parents (e.g., several English programmes use this strategy).

ICT

Regarding the use of ICT, a first fact to highlight is the marked heterogeneity between the selected services/programmes. Indeed, services/programmes usage of ICT range from those that do not use any form of ICT component to App based programmes (e.g., England's EasyPeasy App suggest games and activities that parents can engage in with their children). In between these two boundaries there is also the use of websites in different degrees: for example, with general information about a programme or specific recommendations for parents, or programmes for which a large component is digital (as in the case of the Dutch "Bereslim", a

website used by more than one programme, where parents have access to e-books and e-games as well as tips and information). Additionally, there are programmes that incorporate the use of an App (e.g., the Dutch story-tell app 'Timo en het toverstokje' [Timo and the magic wand]).

Therefore, it is evident that there is a lot of uncovered potential of ICT usage in parenting and family support programmes. This is most evident through the contrast between those that do not use at any ICT component at all and those who are ICT based. This issue elicits yet another concern particularly relevant for ISOTIS goals: how to combine the ICT advantages and potential while guaranteeing that these tools' usage does not widen the educational gaps between the general population and the most disenfranchised groups (noticeably ISOTIS target groups), which foreseeably are faced with additional challenges in dealing with these technologies. At the same time, it is also paramount that the underuse of ICT based technologies by minority groups be addressed, since this is, in itself, a problem that cannot be overlooked. Nevertheless, this is still, as far as we are concerned, an open (but fundamental) question.

3.6. DISCUSSION

Overall positive gains, but scarce information on diminishing (outcomes') gaps

As detailed in the methodology section of the present report, services/programmes could be included in the inventory either by an evidence-based criterion (programmes for which there were high-quality studies available, namely RCTs or Quasi-experimental designs) or by an expert assessment on its promising character. A fundamental issue for the ISOTIS project is the identification of key features or principles that might tackle education inequalities. This means, within the particular emphasis of this task, that it is important to systematize evidence of parenting/family support/education programmes that reduce educational inequalities, namely those affecting ISOTIS target groups (low income/at-general-social-risk; immigrant and ethnic minorities). Therefore, partners devoted special attention in gathering the available evidence for this purpose.

Through the aforementioned evidence-based criterion, a significant number of services/programmes have been included (around 30). With very few exceptions (e.g., NFP programme in the UK), the majority of these show gains regarding outcome measures (for more detail, consult the Annex 2). Nevertheless, for the ISOTIS primary objective of determining the effective features that diminish inequalities, it is not sufficient to know if a certain service/programme does yield overall (for all groups, in average) gains. In fact, one important information relates to the differential effectiveness on the ISOTIS target groups; i.e., if the programme was more, the same, or less effective within the ISOTIS minorities (in comparison to the general population). In this way, we can know that a certain programme will narrow the gaps between ISOTIS disadvantaged groups and the general society. In this respect, it is striking to notice that comparative information on the services/programmes impact on any of the ISOTIS minorities and on the size of its outcomes' gaps is almost inexistent. To be sure, there are (several) studies with (ISOTIS targets) minorities being the beneficiaries/sample. Furthermore, some of these studies show positive results. What we still do not know is if the

service/programme, when applied to both minorities and majority, increases, diminishes or bears no impact on the inequalities between the different groups.

Only three exceptions were found to this rule, all from services/programmes in England: concretely, REAL, PAFT and Bookstart. In one RCT study, REAL showed an educationally significant impact on children's literacy, particularly for sub-groups where children tended to have low achievement in school literacy. Furthermore, the programme effects persisted for one such sub-group (children whose mothers had no educational qualifications) to age seven. Though Bookstart intervention is delivered in English, the reading activities have shown to have the greatest impact on those who do not have English as their first language. In a multisite RCT evaluation, PAFT has shown a positive impact on (i) parental knowledge, with stronger effects for families from a low SES background, (ii) a positive effect on parenting attitudes, and (iii) stronger child outcome improvements for low-income families. In general, low-income families experienced greater benefits throughout the programme compared to moderate-income families.

From the analysis, there doesn't seem to be any particular salient feature(s) unique to these programmes (in comparison to the other identified services/programmes) that might point us to key effective ingredients or principles when tackling inequalities. REAL and PAFT are delivered in different ways and locales such as home visits or group sessions, and Bookstart is delivered through children's centres, which are features shared by many other programmes. They also have in common the use of professional staff: REAL practitioners need to be teachers, Bookstart Intervention is delivered by volunteer's staff from the children's centre, and PAFT practitioners need to be highly qualified, which is considered by the country experts as an advantage, offering quality to the process (PAFT also have a follow-up process to assure that programme is followed with fidelity). Nevertheless, many other programmes do require qualified staff. It is important to mention that the differential effects reported for these programmes may be a result of the advances in the research field of each country. It is possible that other programmes show differential effects across groups, but have not been yet subject to high-quality research studies.

In conclusion, the take-home message seems to be that, although there are a number of existing services/programmes aiming at diminishing children's educational gaps through parental/family support/education, which have been evaluated through high standard quality studies, little is known about the *differential effectiveness* of these same services/programmes between disadvantaged and disenfranchised groups (notably the ISOTIS target groups) and the overall population. This information is needed if one wants to build solid and sound empirical based knowledge on what works effectively to foster a more cohesive and equal society.

Promising evaluation is most dependent on context but there are overarching promising features

It is clear from the analysis that the selection and inclusion of services/programmes as promising by each country's experts is highly dependent on the existing services already available in the country (for more detail please consult Annex 3). Countries with an incipient presence of positive parenting promotion structures may consider as promising services/programmes that aim at very basic needs of families or services that try to anticipate

and intervene in family important social stressors (e.g., unemployment). For example, Czech Republic has identified a service/programme that assumes that it is not possible to promote good parenting practices or quality of the home environment for families that do not live in homes with minimum conditions. “Housing First” is currently being piloted in the city of Brno, guaranteeing Roma and low-income “homeless” families a proper house in which they can live (preliminary results of a on-going RCT seem to indicate an excellent adherence to the programme). Therefore, what might be taken for granted in a context can be considered promising due to its innovative character in another context (e.g., Poland’s “Family Assistant”, due to the delivery of “home-based support for families with children”). Although these are not services/programmes primarily focusing on supporting parenting practices, they can be better understood as pre-requisites, addressing factors that can compromise parenting.

In contexts where there are already services regarding parenting promotion in a strict sense, services/programmes have been considered promising for several reasons: existence of continuous monitoring; “strong” theoretical framework, namely attachment theory; targeting an important group, concretely single parents; focusing on outcomes not common in other services/programmes, namely general well-being; innovative (monetary) incentives for increasing outreach, with interesting results.

It is important to notice that although the promising assessment made by the countries’ experts is most dependent upon each country’s context, there seems to be principles highly valued across countries.

One of these key features is to tailor the services/programmes to meet beneficiaries’ needs. In fact, whenever a service/programme is structured to have the flexibility to adapt to parents/families characteristics or incorporate their knowledge or needs, experts emphasised this as being a strong point. Even so, it is also important to keep present that services/programmes flexibility might vary considerably, either in degree as in nature. For example, it can refer to the possibility of parents choosing the delivery mode (private/individual to group meetings), or choosing which contents will be discussed in specific sessions, or to the design of books and leaflets to address parents’ low-literacy level (e.g., by resorting heavily to pictures).

A specific subject for which several services/programmes were underscored as being tailored to meet the needs of particular beneficiaries is the need to address language specificities of non-native speakers, most noticeably low-income immigrants. As services/programmes do vary considerably in the way they address this issue, and as this is a key issue for the ISOTIS project, this topic is autonomously developed below.

Another highlighted characteristic across countries for considering a programme as promising is the extent to which the service is known by their beneficiaries and rooted in the country/community, which is also associated to the service/programme’s longevity, a criterion stressed by some of the country experts.

Services/programmes that show a high level of articulation with other services, including good interagency work, and/or high professionalism of the workforce were also highly valued.

Although the promising criteria for including services/programmes in the present inventory was an alternative for when there was no high quality evaluation studies, results from studies that did not match the evidence-based criteria were frequently referred to as a reason

for promising. In respect to this matter, it is important to stress that, in some cases, and due to its longevity and universal coverage (e.g., Norway's Health Clinics), evaluations with comparison groups (most noticeable RCT's) are rendered difficult or even impossible.

Keeping up quality while using minorities' members as staff

As previously noted, one of the strategies used to increase outreach and also as a mean to deliver a service/programme in the home-language of a specific minority is to recruit members of minority groups as staff. Although this seems an interesting and promising strategy, words of caution have been voiced in respect to the possibility of a decrease in the quality of the provided service/programme, due to the fact that it is not easy to recruit minority members' staff with the same credentials and training within the non-minority population (this is more problematic as the degree of training and credentials requirements get higher).

While minority members seem to ensure that relationship of trust are built with parents, high-skilled staff is needed to develop respectful relationships and intentional work (Evangelou et al., 2013). Highly skilled and appropriately trained staff is currently seen as a prerequisite for successful delivery of the programmes (Evangelou et al., 2013; Moran et al., 2004). Quite often the resources spent on qualifying staff and the resources spent on the content of the intervention seem to be negatively related to the resources spent on the outreach of a programme. While professionalization of grass roots is challenging, there are some potential powerful strategies that can be putted into place, namely using second-generation well-educated migrants as staff. In addition, to guarantee quality implementation, adequate and intensive supervision with regular monitoring throughout the process, and professional development opportunities may be important.

In sum, programmes may have distinct and sometimes conflicting goals: while strategies to increase outreach or to address the particular needs of some parents may conflict or create tensions with other goals, namely high-quality interactions, there are programme features (such as ongoing supervision and the use of second-generation well-educated migrants as staff) that can alleviate the tension and articulate the use of minorities' members as staff — with the goal of increasing outreach and facilitate the development of a trustable relationship — with the maintenance of a high threshold level of quality regarding service/programme delivery.

Not enough emphasis on multicultural (nor intercultural) education potential

Consistent with ISOTIS project and objectives, several of the services/programmes that were included in the present inventory target social and cultural minorities (e.g., low-income, ethnic minorities or Roma). As we have previously seen, some of these services/programmes go as far as using minority members as staff for increasing outreach and facilitating the establishment of relation of trust between staff and families, with the additional advantage of delivering (when necessary) the service/programme in the home-language of the minority group. This subset of services/programmes does generally value the use of the home-language in parents-children interaction and that is explicitly recognised within the programme's content.

Research has shown that proficiency in the first language is not only relevant for the development of language and communication skills of the children, but more importantly to develop a multicultural identity without losing the link to their cultural origin. Previous research

has shown that a lot of immigrant parents in different countries and contexts articulate the wish for more respect for their home languages and better implementation of different languages within the educational systems (Hachfeld, Anders, Kuger & Smidt, 2016).

Having said this, it is important to highlight that the vast majority of the included programmes do not intentionally target multicultural goals (with one exception, namely Germany's Rucksack), which is the more surprising if one realizes that several of these programmes target cultural minority groups. For example, in services/programmes aiming at language and literacy development that simultaneously recognize the value of the home-language, it makes sense that contents about the added value of bilingualism (at the personal but also societal level) as well as of the pivotal role that language plays in the definition of each person and group identities would be included. To be sure, when faced with multilingualism issues within a society, services/programmes that address this topic should not only value language pluralism because it might concur to the learning of the country's language (or at least will not hinder it), but could include the very topic of multilingualism and its respective challenges as a part of the content of the service/programme.

By extension, this argument is valid not only for multilingualism issues, but also for multiculturalism in general. Multicultural goals would be essential in order to downplay intercultural conflict and stereotype threat. From an equality oriented perspective, it is possible and desirable to articulate objectives of promoting the home learning environment or strengthening parent-child relationships with multilingualism and multiculturalism content, a potential that one should fully take advantage of.

Improving social and cultural capital

Social and cultural capital is of the utmost importance if one is aiming at tackling the gaps between disadvantaged and non-disadvantaged groups. Generally, social capital is the set of relationships — social networks, bonding similar people and bridging between diverse people, with norms of reciprocity — that provide access to information and resources. Cultural capital refers to the cultural skills and knowledge (e.g., knowing how to dress or speak) needed to engage with services in a particular culture, resulting in social, economic and status advantage from whomever possesses it according to high social-status groups standards within a society (Lee & Bowen, 2006).

Some of the services/programmes included in the present inventory target social capital outcomes (e.g., England's FAST or the Dutch Home-Start), namely the development and strengthening of social networks amongst ISOTIS minorities' parents. In addition, the data suggests that programmes that foster bonds between parents and aim at increasing and strengthening parents' social networks have unusually high retention rates. Still, it is important to stress that none of the programmes explicitly declares as an objective of the programme the promotion of minorities' cultural capital.

However, consistent with an ecological framework, it is important to distinguish gains at the local mesosystemic level (for example, improvements in the parents' social network) from gains at the macrosystem level (for example, knowledge of the cultural codes shared by high socioeconomic families). In fact, one avenue that might prove fruitful in tackling educational inequalities would be through the deliberate promotion of minorities' cultural capital. To the very

least, cultural capital, and the fit between minorities' culture and the culture of the larger society, should be considered in programme design and implementation, given it can provide important insights about the potential success of services/programmes within and across system levels. For example, one programme can help parents gain access to beneficial information, parenting skills, or resources available in the social network, whilst maintaining or reinforcing the segregated character of that particular geographical area. Therefore, it is possible that a service/programme shows gains in specific outcomes, while conserving the pre-existing gaps in the social and/or cultural capital of disadvantaged groups relative to the majority society at the macrosystem level. In fact, it is even possible that the existence of some targeted programmes do reinforce a segregation subculture, even if expanding social networks at the local level, but augmenting social and cultural capital differences between minorities and majority. One major issue relates to the system of values, and how to improve consistency in values and practices across services, families' culture and the culture of the larger society.

RECOMMENDATIONS

The analysis of the system contexts and overview of evidence-based and promising practices has led to recommendations for potentially effective interventions that are summarized below.

Services/Programmes design

The inclusion of a service or programme should be carefully assessed against the country-specific context and the services that are already provided. The gains of programmes that have been proven effective within a given context cannot be taken for granted within another given context, either because they may not add to the quality of the existing services, or because they do not respond to the needs of that particular context. Programmes may also not work in other contexts because they are not in line with shared pedagogical or societal beliefs (such as educational beliefs, respect of family privacy, etc.). Programmes have to be adapted to the country-specific contextual needs.

Further, services/programmes have to be designed or adapted to the degree of disenfranchisement of each specific group. Different levels of distrust in the system's (country's) institutions may require distinctive goals and outreach strategies for dissimilar target groups. Outreach to the target groups is a prerequisite for high quality approaches and interventions to be effective. Accordingly, it is obvious that ensuring outreach has to be one priority when adapting, developing and implementing programmes. However, to be effective, the process and implementation quality of the interventions have also to be ensured. Naturally, both aspects of successful programmes need structural resources and adequate financing.

Services/programmes need flexible staff to address parents' needs while keeping up standardization; this is particularly the case when dealing with families and parents who do not speak the same language of the programmes' staff, or when dealing with disenfranchised groups who may need time and support to trust institutions.

Multicultural beliefs, as opposed to egalitarian and assimilative beliefs, seem to be key prerequisites to develop and carry out high quality programmes that meet the needs of multicultural groups. Beliefs are relatively stable but develop over time, so professional development programmes that foster multicultural beliefs need to be implemented carefully, and sensitivity for multiculturalism needs to be transferred to all levels of service/programme development and implementation.

Only few services/programmes consider the first languages of immigrants or their promotion in their programmes and staff development. However, this aspect should be revisited to address this important issue, because it may be an important factor, not only for outreach but also for the compliance and trust of participants in services/programmes.

ICT-tools may have great potential to foster particularly outreach and compliance of participants and provide new ways for networking, building communities of trust and share ideas to overcome challenges at local, regional, national or even international level. ICT-tools may be particularly useful for integrating the first languages of immigrants within programmes. Thus, existing effective programmes should be revisited and assessed against potential benefits of enriching them with ICT-based tools. At the same time, ICT-tools usage may raise additional challenges when aiming for equality, namely because deprived groups might foreseeably have harder access to new technologies. Therefore, it is paramount to take this issue into account

when designing programmes that take advantage of ICT-tools.

Programme implementation

After successful initial implementation of a service/programme, the service/programme needs to be monitored and evaluated against its aims, continuously. Thus, continuous long-term implementation checks need to be planned, and possibilities to reflect and adapt contents and delivery modes of the programme need to be enabled. There may be differential adaptations necessary regarding dissimilar target groups and the aims and core areas of the programmes may also differ between target groups after a careful assessment of the specific and individual needs of different target and minority groups.

Research

Comprehensive high-quality formative and summative evaluation studies are needed, particularly in those countries with underdeveloped research in this area. Furthermore, international comparative studies that examine the effectiveness and factors leading to high outreach and success of parenting support programmes would be very valuable. It would be particularly interesting to study the needs of families participating in such programmes in different contexts to disentangle effects of context and target group.

Studies on successful consideration of the first languages of immigrant groups as well as studies on successful implementation of ICT within their programmes are highly in need.

When measuring the efficacy of a service or programme, one should also assess its impact on the degree of disenfranchisement of the most vulnerable groups (e.g., through the assessment of the degree of trust of minority groups in the institutions that provide the service), as the differential impact it might have on different groups, namely disadvantaged minorities and non-disadvantaged groups. Different system levels of implementation should be considered in research designs.

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