EuroHealthNet

EUROPEAN PARTNERSHIP FOR IMPROVING HEALTH, EQUITY & WELLBEING

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EuroHealthNet Country Exchange visit

# Giving all young children a healthy start – an exchange on evidence-based interventions

12-13 June 2018

Hosted by Santé Publique France

Santé publique France

# Introduction

EuroHealthNet and Santé Publique France organised a country exchange visit on 'Giving all young children a healthy start – an exchange on evidence-based interventions'. The aim was to explore ongoing initiatives relating to the first 1,000 days of life and to facilitate exchange of related best practices, best policies, and experience between senior staff from national and regional organisations.

A total of 49 participants from 15 countries took part. They represented EuroHealthNet member organisations and organisations across France involved in child health and well-being. EuroHealthNet members can access all presentations in the Member's section of the website: www.eurohealthnet.eu.

The visit took place within EuroHealthNet's contract agreement with the European Commission DG Employment, Social Affairs and Inclusion under the EU Programme for Employment and Social Innovation (EaSI). The event was hosted by Santé Publique France.

# Session one: Overarching Approaches

## New Health Strategy 2018-2022: Special focus on the children and young people

**Zinna Bessa, Directorate General of Health, Deputy Director**

In general, the health of French children is good, but there is a need for action on health inequalities. Four figures demonstrate this:

1. 21% of the children of blue-collar workers are obese, compared to 8.5% of children of white collar workers.
2. 31% of the children of blue-collar workers drink sugary drinks every day, compared to 8% of children of white collar workers.
3. 59% of the children of blue-collar watch at least one hour of television per day, compared to 25% of children of white collar workers.
4. 47% of the children of blue-collar workers brush their teeth several times per day, compared to 60% of children of white collar workers.

This calls for action to reinforce prevention policies and working tackling the roots of social/health inequalities.

The responses have come in three parts:

1. A 2016 law to modernise the health system
2. The development of a national health strategy 2018-2022
3. The operational translation of the prevention aspect of the strategy, which has become the first National Prevention Plan

The new National Prevention Plan (.pdf), focussing on the first 1000 days but going up to 25 years, was launched March 2017. It is directed at the whole population but focusses on the most vulnerable. The plan addresses the political level, setting standards and guidance – local agencies within the region are therefore essential for implementation. It contains 160 measures, of which 25 are 'lighthouse measures' which mostly concern perinatal health, children, and youths. Inter-sectorial and inter-ministerial collaboration has been key to its development.

The plan covers 'promoting healthy behaviours and creating healthy environments', which includes substance misuse and addiction work, vaccinations, and endocrine disruptors. It also covers 'Care and support during pregnancy and early years', which includes enhancing early assessment of women's medical, emotional and social needs; promoting good practice in delivery suites; and strengthening postnatal care through home visits

A lot of effort is being made in reinforcing prevention for children and youths. Now, 20 mandatory checks have been introduced. Currently, take-up rates for checks decline rapidly after two years particularly amongst vulnerable groups and migrant populations. The new prevention act aims to change this. While the checks are mandatory, there is no penalty if they are not carried out. The aim for vaccinations for example is to convince, not punish. A 'child health pathway' has been developed, along with an obesity prevention plan for 3-8-year olds.

Youth work covering addiction, mental health, and sexual health is also included – for example a programme similar to the UK's 'c-card' for the distribution of condoms has been launched. Examples of efforts to promote health in every living environment include health promoting schools, and a special programme for juvenile offenders. The rollout of health promotion programmes for children will include social and emotional skills development, and the involvement of children and young people in health promotion.

Specific efforts are being made to target key, vulnerable populations. Intersectoral work is ongoing to make sure prevention programmes are available to young people in social housing and occupational integration. Partnerships have been made with ministries of education, higher education, agriculture (including vocational secondary schools), and justice (targeting juvenile offenders).

## Discussion

*Under the new plan there are 20 mandatory checks – are there as many in other countries?*

In Slovenia, yes; there are checks in the hospital, at home, and in school. In the Netherlands, the number is similar but the approach is flexible – there can be more checks for vulnerable children and less for those that seem to be in a stronger position. In Wales, about half the planned checks are not mandatory, although there is a safeguarding system which will trigger health visitors to take action and work more closely with the family. There are fewer in Germany and no check-ups take place after the age of 14. In Finland, parents get benefits such as a baby box when they go to the childcare clinic and babies meet the doctor 12 times, then once per year in childhood. In Spain there are currently ten mandatory checks. Improving health promotion and training for health professionals to

promote healthy lifestyles is a priority; they are doing prevention well, but focus much less on promotion.

In France two barriers have been noted: it is hard to get health professionals to work on prevention, and there is reluctance for professionals like nurses and pharmacists and midwives start doing the work traditionally done by doctors. In Wales, health visitors and nurses are doing most of the checks and the role of pharmacists is growing, while doctors and paediatricians are doing the specialist work; there is a rule 'only do what only you can do' – meaning professionals should only do what their training makes them uniquely able to do. In Slovenia the need to integrate different professionals more in the future has been noted - data exchange is currently an issue.

## Support Parenting - National strategy

**Catherine LESTERPT, Directorate General of Social Cohesion, Deputy Director**

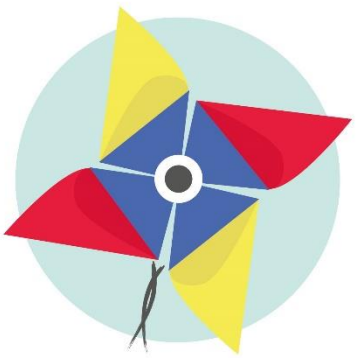
The National 'support parenting plan' 2018-2022 is a multi-sectorial strategy for work on the ground. The focus of the current stage of work is on motivating and informing stakeholders to put the strategy into action. It's about making objectives and guidelines clear and strong, and reinforcing action. It's a national strategy, but local leadership remains important. A Roadmap is about to be put in place, and action will start in January next year.

The strategy covers four transversal issues:

1. Parenting and gender equality.
2. Parenting and poverty.
3. Parenting and disability.
4. Parenting overseas.

And eight main topics:

- Supporting the parents of young children - includes kindness toward parents, provision of specific skills, identification of hazardous situations, coordination.
- Supporting the parents of 6-11-year-olds – includes training for professionals, digital issues.
- Supporting parents facing youth issues – general parenting support for specific issues, awareness of local services.
- Developing parental breaks
- Improving family and school interactions for a unified and trusted educative community
- Managing conflicts and protecting family ties
- Encouraging peer-support
- Improving family information



A national parenting support day was held on 30th May 2018, and working group planning and action is taking place over summer 2018. In September / October 2018 operational roadmaps will be drafted, which will be

endorsed and released in November/ December. The operational kick off will be in January 2019, and the steering committee will produce a status report in spring 2019.

### Discussion

In Scotland a similar strategy was introduced. The aim was to introduce a 'named person' who would be responsible for coordinating support, but this has faced opposition and a court case. The opposition has been mostly about data sharing – people don't want information shared with organisations they have little contact with, like social services, sometimes in fear that it will be used against them. As the French strategy hasn't yet been implemented yet, it is unknown if there will be any reluctance or inertia. If a family is reluctant, the plan is to either step back and see if there is anything that can be done or fall back to child protection measures. There was already an initiative in 2007 to support the families of criminal children from which knowledge and experience has been gained; there the focus was on supporting families, not watching them - respecting and listening to them rather than getting information. Some structures rely on anonymity and there can therefore be no exchange of information. Experience has also been gained from a programme established to assess psycho-social difficulties in the fourth month of pregnancy. This did not initially go as planned as most people that took up the offer were not the most disadvantaged or in need. Now, to target these groups, the title has been changed and more flexibility introduced in the process of getting appointments.

The group discussed a new paradigm: the better we are prepared for parenthood the better health will be. This depends on establishing a good relationship and knowledge and understanding the social, environmental and other determinants. It also concerns raising awareness amongst all: where you are, what difficulties you have, what can be done.

# Session two: Ensuring Supportive Environments During Pregnancy and Early Childhood

## French perinatal health indicators

**Nolwenn Regnault, Santé publique France**

In addition to EuroStat's collection of ten indicators on perinatal health, EuroPeristat – a network of 29 countries of which France is part– is working to produce a high quality, innovative, internationally recognised and sustainable European perinatal information system. They published reports in 2008 and 2013 using 2008 and 2010 data respectively.

In France there is no medical birth register but since 2010, a system for health data has been established. A list of sources of data relating to perinatal and early childhood periods is available in the presentation.

Some headline figures were presented:

*Demographic context and maternal characteristics:* Birth rates have been decreasing since 2010, but France still has the highest fertility rate in Europe. The average maternal age increased to 31 in 2015.

*Social conditions of women in the perinatal period*: A big increase in educational level and maternal employment rates has been noted. The latter is notably high compared to the rest of Europe (more than 70%). However, levels of social deprivation and risk are increasing. 25% births have at least 1 foreign parent, but this is not a major increase.

*Maternal risk factors*: Maternal smoking rates remain high – there is a 30% smoking rate before pregnancy, and 50% quit while pregnant. The rate of women quitting during pregnancy has remained stable, so reducing smoking rates before pregnancy would help. Alcohol and cannabis use are difficult to estimate, but measured 5.5% for alcohol use in 2012, and 2.1% for cannabis use in 2016. Overweight and obesity rates are high, but lower than many countries. There are clear geographical differences: people in overseas territories are much more likely to be overweight or obese.

*Following and monitoring pregnancy:* pregnancy monitoring is roughly in line with recommendations, but the early prenatal visit (4 month) us underutilised. The women going to the appointments are not necessarily those that need it most; there is still a problem reaching the most vulnerable.

*Maternal and infant mortality:* The main cause of maternal mortality is severe post-partum haemorrhage. Mortality is higher in overseas territories and amongst migrant women. The rate of preterm birth is growing and is highest in overseas territories. Levels of perinatal, neonatal, and infant mortality remain stable but are declining slightly – although neonatal mortality rates are still high at 17$^{th}$ in Europe.

*Breastfeeding:* France has one of the lowest breastfeeding rates in Europe, and those that do breastfeed end relatively soon – this could be linked to women returning to work.

## Discussion

The groups acknowledged that there is a general information gap across Europe, for example on mental health and post-natal indicators. EuroHealthNet recently published a policy précis describing the current sources of health data and ongoing initiatives to progress. Partners were urged to get involved shaping further initiatives.

The participant from Slovenia noted there was an issue with maternal suicides in their country, so work on maternal depression has been undertaken.

It was noted that there is room for improvement in France concerning the medical visit in the fourth month of pregnancy in terms of focus on promotion and prevention, and targeting the most vulnerable.

To reduce tobacco use in France '*Mo(i)sans tabac'* (Me/month without tobacco) has been introduced, based on the British 'Stoptober' model.

## Birth in a Baby and Mother Friendly Hospital IHAB-France

**Dr Caroline François, Medical coordinator and Kristina Löfgren, National coordinator, IHAB-France**

The 'Mother and Baby Friendly Hospital' concept was launched by UNICEF in 1991. The objectives are to protect, promote, and support breast feeding. It is based on 10 recommendations for maternal health. The initiative is free from commercial interests and is evidence-based.

Mother and Baby Friendly Hospitals (BFH) is a global network but there are big differences between countries. There are 800 BFH in Europe. New guidelines are expected in 2018. It is being used to reduce regional inequalities.

In France BFH is supported by UNICEF France. Since 2008 it has also involved in neonatal units.

BFH is based on 3 principles:

- Focus on the individual mother and her situation
- Family centred care, supported by the environment
- Continuity of care

And 12 steps based on scientific evidence.

The first three steps establish the foundation:

1. Staff commitment and a written infant feeding policy
2. Staff competency – training for midwives, nurses etc.
3. Antenatal guidance for mothers on the importance of breastfeeding.

Throughout there is a focus on respecting the rhythms and needs of newborns, fathers' involvement in care, and promoting parent-child attachment.

4. Focusses on skin to skin contact

5.,6.,8, and 9 look at supplementing, responsive feeding, and nutrition in neonatal units.

7. Concerns in-rooming

5. and 8. Concern using formula, according to the choice of the mother.

10. Concerns post-discharge support including support groups such as mother and baby groups.

In France an 11th recommendation has been added. This concerns protecting mothers from the influence of advertising. A further 12th step is integrated in all other steps: mother-friendly care during labour and delivery - the needs and desires of the mother are respected, the mother/ baby bond is promoted.

To qualify as a BFH, candidates first complete a self-evaluation tool. Then a three- to five-day, four-part on-site assessment takes place, which has a fee attached. A group of 20 professionals help to decide whether the hospital meets the criteria.

In France, 6% of births take place in baby friendly hospitals. Most are in the north of the country, where there are the most inequalities. Interest is growing.

## Discussion

Slovenia has long tradition of breastfeeding. The starting rates are high, but there is no data on continuity; Slovenian mothers get one year of maternity leave which should encourage breastfeeding, but the current generation seem to be turning to formula for convenience. Participants noted that different sources provide different information on breastfeeding– the WHO gives different advice to gastroenterologists for example.

The reason that not all hospitals are Mother and Baby Friendly is because the criteria are strict. New national recommendations in coming years might help with mainstreaming.

It is hoped that these ideas can be integrated in the education of midwives and related professions.

# FEES project: Pregnant women and environmental health

**Corinne Schadkowski, Director, and Marie-Amélie Cuny Association de prévention de la pollution atmosphérique**

FEES stands for 'Femmes Enceintes Environnement et Sante' or 'Pregnant women – environment and health'. The objective is to reduce the exposure of pregnant women to pollutants in air, food, and cosmetics. It is operational in Northern France and is supported by two organisations: APPA (Association pour la prévention de la Pollution Atmosphérique / Association for the prevention of atmospheric pollution) and Mutualité Française Hautes-de-France. The project began in 2011 and the impact on public and professionals was evaluated in 2015.

FEES actions include: training current and future perinatal professionals; supporting professionals in the implementation of actions; providing information for future and young parents; creating and distributing tools; and assessing communication between partnerships.

Training for midwives takes three half days: one on air, one on food, and one on cosmetics. A review of the training gave positive results; it met the participants' expectations, and most midwives were able to give three pieces of advice after training. Most concern the choice of cosmetics, the preparation of baby's room, and limiting the use of baby wipes.

FEES surveyed future and recent mothers, and future and recent mothers who had taken the training. Most were aware of the links between the environment and health, but most concerns were about ambient air, agriculture, and nuclear power rather than about indoor air, cosmetics, etc. People are concerned but think they can't act. Young women and health professionals are the least well informed. The most understood information was 'avoid smoking and tobacco smoke/avoid wipes' and the least understood was 'do not heat food in plastic / choose cosmetics wisely / choose cleaning products wisely /maintenance of heating apparatus'.

## Discussion

It's difficult to measure individual impact of endocrine disruptors, but there is growing evidence about the effects of pollution. There is a lot of interest in and research into this area at Santé Public France (SPF). There is also an inter-ministerial committee in the French parliament pressuring for more action on the topic of pregnancy and environmental health. An important open question is how to reach precarious and vulnerable people.

At Pharos (NL), they are working with the relevant target groups to design communication materials. FEEES began by testing their material with about 30 people with a low level of literacy. The project began in the north, but is spreading to other areas due to high level on interest

Interest in this topic in other areas of Europe appears to be weak but growing.

# Wales : Low Birth Weight Programme in Cwm Taf

**Angela Jones, Cwm Taf Public Health Team, Public Health Wales**

Cwm Taf, in south Wales, has the highest rate of deprivation in the country. The population is 300,000 and there are about 4,000 births per year. The low birth weight rate is 95 per 1000 live births. The low birth weight rate is a concern as it is linked to increased infant mortality, illness and developmental problems in childhood, life limiting conditions in adulthood including cardiovascular disease, and an increased risk of having low birth weight children. It also contributes to persistent health and social inequalities. The biggest primary risk factors globally are smoking and exposure, bacterial vaginosis, and severe gum disease.

Wales has a good amount of data as the senior midwife has set up her own database. This data has been used to identify the biggest risk factors of low birth rate in the region. As reflected by global data, smoking is the leading risk factor. The next big risk factor is having a mother with a BMI 30 or more (relating to early births due to complications from high BMI). The third risk factor is teenage pregnancy.

The Office for National Statistics provides data on teen pregnancy, so hotspots could be identified. Work was focused on those areas, for example making a condom card scheme available, as well increasing access to long-acting reversible contraceptives (LARC) and Emergency Hormonal Contraception (EHC). In addition, sexual health advisors went into the community. Nationally, the teen pregnancy rate is going down, but in Cwm Taf it is falling faster.

Hotspots in for smoking and obesity rates were also identified. At the start of the action, roughly 30% pregnant women were smokers and 30% were overweight or obese – both rates are higher than the national average. A questionnaire was conducted in the post-natal ward to see why people were not taking up smoking cessation services. It appeared that most were not being referred by midwives to cessation services, as midwieves were uncomfortable starting the conversation on this issue. A 'Models for Access to Maternal Smoking Cessation Services' (MAMSS) was therefore established. Under this scheme, midwives used a $CO^2$ monitor during a home visit, and used the

results to start a conversation; this also helped to identify $CO^2$ pollution from other areas. An automatic referral / opt out system was also introduced. The best model for cessation during pregnancy has not yet been established; different regions have tried different models.

To tackle the issues relating to high levels of obesity, a 'Bumpstart programme' for women with a BMI of 35+ was established. These women are supported by 'healthy lifestyle' midwives and have longer consultations. The aim is to restrict weight gain to 3-5 kg during pregancy. Women with a BMI of 40+ have consultant lead care. Interim reports seem positive, with a reduction in referrals to the neonatal ward, but not quite with statistical significance yet.

### Discussion

A participant asked about the role of 'healthy lifestyles midwives'. It was explained that these are 'normal' midwives who have received extra training, for example in smoking cessation and in a new programme called 'food wise in pregnancy'. These were new positions, and the training was given as part of those roles. However, training about how to have potentially difficult opening conversations was offered to all. The training involved midwives from another UK region, who had already tested the scheme, demonstrate good and bad dialogues through role-play.

## PANJO: Promoting health and attachment of new-borns and their parents

**Sandie Sempé, Santé publique France**

In 2011 there were major Health Inequalities in France, therefore the PANJO programme was developed. The objective is to develop an evidence-based preventive intervention targeting families who live in psycho-socially deprived contexts, in order to support good development of all French children.

The main objectives of the PANJO intervention are:

- Support responsive parent-child relationship
- Promote appropriate use of social and medical services
- Promote engagement with local and personal network
- Promote healthy behaviour for all family members

The development of the programme was guided by three main sources of evidence:

1. Nurse Family Partnership trials (David Olds, 1977-1994) which involves home visits up to the age of two, focusing on mothers in most need.
2. Gomby et al, 1999 which showed that to be effective, home visits must start early and last for a long time, that visits must be defined but also respond to family demands, and that home visitors must be trained and supervised.
3. CAPEDP project 2006-2011, which looked at dysfunctional interactions between mothers and children, and self- confidence in parenting skills.

When designing the programme, the developers looked to see what existing skills and experience could be combined. Child maternal protection centres (PMI) already existed, which was a good start. PMI's mission is the prevention of health problems, prevention of child abuse, and support of parenting skills; they were already doing one or two visits when needed, so this could be used to develop the PANJO programme. The union of paediatric nurses was also involved, as were some psychologists from the CAPEDP project.

Test implementation, and the development of training and practice guidelines took place in 2014-2015. The aim was to see if the project was feasible and acceptable to professionals. The results of this test phase showed that professionals were happy with it, but felt that it should not just target those at social disadvantage – they felt that as it's a French provision, it should be available to all. It also proved difficult to follow families for two years.

These results were considered for the next and current rollout, launched in 2017 with help of l'ANISS, 'The agency for new social and health interventions'. PANJO is now being implemented in 11 regions with 22 teams working with with 157 families.

The current version of PANJO targets first time mothers who express loneliness and isolated feelings. There is no fixed number of visits, but a minimum of six are carried out: two visits are pre-natal, and four are post-natal. The visits last for about one to one-and-a-half hours and include at least 20 minutes on attachment. They take a collaborative and positive approach. A pack of resources has been developed, including cards with images showing issues mothers may wish to talk about as sometimes using images can provide a discrete way to raise potentially sensitive issues. Evaluation of the current rollout is ongoing.

## Discussion

The group discussed the difficulties of reaching mothers in need. PANJO was meant to involve more than 200 families, but it was not possible to reach that many. Outreach is a problem; parents, particularly those facing vulnerabilities, don't know about the PMI centres, and the centres don't know about the parents. It was hard for the centres to start doing outreach. Their priority criteria for support and vulnerability are different for each department in France, so a new criterion was needed for the implementation of PANJO and 'loneliness' was chosen. Currently, PANJO is not providing services to many people on low incomes, but to those who are vulnerable for other reasons. It was noted that in France and Slovenia, people prefer health over social criteria as it is considered that the former is subjective and the latter objective.

In the UK the number of home visits was decreased so much that children were coming to school with extreme speech and language delays. The Nurse Family Partnership model was tested with eight visits in first year and some further visits in the second year; the benefits are now being seen. In France centres are resistant to targeting the poorest – it was noted that the programme may suffer from this universalism. There is also a need for advocacy work. In the Netherlands the decentralised nature of services makes it difficult to convince people to get involved. In Germany, research and evaluation of the German Federal Initiative for Early Interventions conducted by the

National centre for Early Interventions (NZFH[1]) at BZgA have found that the need and potential for the further development of early intervention networks is high; more than half of municipalities surveyed by NZFH reported that there is a shortage/lack of qualified health staff/professionals providing care to families; and data collected indicates that early interventions do not always reach the families who are most in need of them. The NZFH has worked on the development of competencies of professionals (family midwifes, nurses for family health and paediatric care) in early interventions and has developed qualification modules for these professionals[2].

The Incredible Years approach, an American model, has also been trialled in Norway, Slovenia, and the Netherlands. It connects health, social, and parenting support. In Scotland a programme for parents of children aged four and up who are at risk has been developed, which is a combination of Incredible Years and 'Triple P'[3][4].

## Discussion session – conclusions from day one

To discuss the outcomes of the first day, the group split in three to answer the following two questions:

**What did you hear that was new and inspiring? What would you like to see implemented in your country?**

Participants were impressed by the work in Wales, particularly the ability to reach vulnerable groups, parenting strategies, and indicators. The use of local data for the MAMSS intervention and using that to develop specific interventions for vulnerable groups was identified as positive and something which could be relatively simple to transfer and translate.

Participants supported the idea of a perinatal survey at cross-national level but agreed that political will may be lacking and therefore financing may be difficult.

From the presentation environmental factors and pregnancy, participants noted there is a lack of awareness and a need for more knowledge and capacity. There was a lot of information provided that was new to participants.

There was a discussion on the role of midwives at home, as differences were noted between countries/systems about who can deliver home visits. How can a link between baby friendly hospitals and the rest of the system be made?

A multisectoral approach is needed in all, with national and long-term plans.

Participants are interested by the Panjo programme and its future developments.

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[1] https://www.fruehehilfen.de/

[2] https://www.fruehehilfen.de/serviceangebote-des-nzfh/materialien/publikationen/qualifizierungsmodule/?L=0

[3] http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/psychology-of-parenting/psychology-of-parenting-project.aspx

[4] https://beta.gov.scot/publications/universal-health-visiting-pathway-scotland-pre-birth-pre-school/

**What are the challenges?**

Political issues were identified as a key challenge - "If you don't have political will, you can't get far." It was noted that several countries have decentralised systems making it difficult to get comparable data to fully understand what's happening. Many systems focus on the clinical aspects rather than on prevention.

Participants had several questions arising from the day's discussions:

- How can staff who are already busy be motivated to take on new things?
- How can new projects be implemented when systems are already understaffed?
- How can people be trained in mother friendly systems?
- How can a link with health systems be made?
- What kind of data should be collected and how?
- How can perceptions of high cost be managed?
- How can best practices be exchanged?
- What is the best way to get an understanding of what an individual really needs?

## Discussion

There were questions about EU-level mechanisms that could be applied to support efforts in Member States around child health; processes can be complex and funding difficult to access. There was an inquiry about opportunities in the context of the EU Public Health Programme, the collection of good practices in the field and the role of the EU Steering Group on Health Promotion and Disease Prevention. The Steering Group can help the EC select those good practices that they feel should be implemented further across the EU and scaled. It was noted that they criteria being applied to select the practices is currently quite narrow and encourage a 'risk-based' rather than a broader 'social-determinants' based perspective and approach. Some partners however knew the national representatives sitting on the Steering Group and felt that it could be possible to broaden the criteria.

# Session three: Addressing the wider determinants of young children's health

## The EU context and EuroHealthNet's work on early childhood health

**Ingrid Stegeman, EuroHealthNet**

European data indicates that on average one in four children in EU Member States are at risk of poverty and social exclusion (AROPE). In many EU Member states this number is even higher. This is a grave concern, since these children represent our future. The available data in the EU also reflects

that for every step down the socio-economic ladder children experience higher levels of physical and material health problems that will affect their future health and life opportunities.

EuroHealthNet has coordinated two EU funded research projects that addressed what can be done to reduce health inequalities amongst children (DRIVERS, 2011-2014 and GRADIENT, 2010-2012). Both projects developed recommendations on what can be done to reduce these. Amongst the findings were that programmes offering intensive support, information and home visits using a psycho-educational approach and aimed at developing parent's and children's skills showed the most promising outcomes. Little evidence could however be found from countries outside of the UK, and more evidence is needed on the effects of early year interventions outside of the UK.

A number of high-level policy mechanisms at EU level can offer support in efforts to improve outcomes for vulnerable families and children. The EU Semester Process for example began in 2010 to enable EU member states to coordinate their economic and fiscal policies throughout the year and address the challenges facing the EU. Increasingly it is also focussing on and issuing recommendations to Member States that are related to the labour market, social protection, and health-related policies, since it is becoming increasingly recognised that these affect economic performance and political stability in countries. The EU has also recently developed an EU Pillar of Social Rights, that sets out a number of key principals and rights to support well-functioning labour markets and welfare systems. A 'Social-Scoreboard' has been developed to provide an overview of how EU MS are performing in relation to a relevant set of 14 headline indicators and to enable them to benchmark performance.

The EU Recommendation on Investment in Children is also an important policy tool deriving from the EU level that outlines what can be done to improve child well-being across the EU. Recently, the EU commissioned a report to assess progress in the implementation of the Recommendation. It found that this has been inadequate and that a more comprehensive and multi-dimensional and coordinated approaches are needed. The EU encourages EU Member States to apply funding opportunities available like e.g. the European Structural and Investment Funds to address the weaknesses these processes identified.

## Child and young people poverty prevention and control strategy

**Olivier Noblecourt Interministerial Delegate for Child and Young People Poverty Prevention and Control**

A social investment strategy targeting young people and infants has been developed in France. This includes the creation of new crèche places, and other initiatives to support social and other development. It involves redeveloping ideas about supporting parents and launching social centres, and offering a good quality welcome for all.

The strategy is also seen as a way to guarantee that the fundamental rights of children are being met in relation to their day to day needs, by e.g. ensuring they have access to sufficient nutritious food. Initiatives include the provision of a balanced breakfast at school, one euro menus for children, and

the possibility for companies to offer products at lower prices, and then get money back. Efforts are also being made to ensure children have access to housing, and to bring them off the streets.

### Discussion

Participants noted that there is always a difficulty to identify children in most need, without stigmatisation. It was also noted that, while interventions – particularly around food - can be delivered in schools, that can leave families in a difficult situation during the school holidays.

Experiences in different countries were discussed. In the Netherlands, the approach is totally different- it's all locally managed, not centrally as in the French plan. In Wales, there is a 'flying start' programme in the most deprived areas, and a deprivation grant for schools which can be used to provide free school meals. Schools are open a few days during the holiday with sports activities and hot meals provided then. In Spain, a new childhood poverty strategy will soon be developed – it could take a similar form.

## Family Allowance Fund (CNAF)

**Pauline Domingo, Familial and social policies Department Deputy Director**

The *Caisse nationale des allocations familiales* (CNAF, French family allowance fund) is the 'family' branch of the French social security system. There is one CNAF per department.

The objectives are:

- Contribution to the costs associated with having children
- Helping the most vulnerable families, fighting against poverty – this is a more recent aim
- Supporting the collaboration between working and family life- this includes support for child care and parental leave.
- Helping parents fulfil their role - there are a number of new policies to help support parents.

Children from one parent families are particularly at risk. In France, 19.9% of children live in poverty; this figure increases to 40% of children in single parent families.

Support includes:

*In early childhood*

- Birth payment of €923, given dependant on family resources.
- 'basic rate' benefit, given dependant on family resources and ranging from €92-184.
- Financial support during parental leave, for one or two parents for a maximum of 24 months.
- Support to finance childcare

This amounts to about 12 billion Euros. A further three billion Euros are invested in early childhood services and their functioning.

*In childhood and youth*

- Child benefit- available for all but amount based on family resources. Paid until the child reaches 20
- Income support – concentrated on families with multiple children. Targeting the poorest and variable according to family resources.
- Back-to-school allowance. Targeting the poorest and variable according to family resources.

One billion is also spent on centres which offer classes before and after school and during the holidays. There are also funds available to finance structures that help parents like community cafes and centres.

Recently a programme has been developed to support parents who are separating or have separated. This includes advice, support for mediation services, and family support allowance targeted at the most vulnerable.

Activities to support and help relationships between parents, children and schools/ professionals are also being financed.

A block of aid focused on poverty reduction also exists. This includes an 'Active solidarity income' (RSA) which guarantees a minimum income, depending on family composition - for example, €800 for a single person with a child. An activity premium supports over-18s in a professional activity living in a family with modest resource. 27% of families with children also receive a housing allowance.

Before help, the level of child poverty is 32% which diminishes dramatically following aid.

**Impact of family benefits, welfare benefit and housing allowance on the rate of child income poverty, according to the family configuration in 2015 (source: Drees / Insee)**

| | After income tax | After family benefits | After welfare benefit | After social benefit |
|---|---|---|---|---|
| ENSEMBLE | 32% | 23% | 22% | 17% |
| Couple with 1 children | 13% | 12% | 11% | 9% |
| Couple with 2 children | 17% | 12% | 11% | 9% |
| Couple with 3 children or + | 45% | 28% | 27% | 22% |
| Single with 1 children | 47% | 43% | 37% | 25% |
| Single with 2 children or + | 70% | 53% | 51% | 39% |

## Discussion

Regarding groups where parents can meet, discuss, and share: in the Netherlands it's difficult to reach the parents that need it most. There are gaps in access, which need to be addressed.

Regarding the high levels of child poverty with single parent families of two or more children, an important component of the French strategy is to remove blocks to parental employment.

Participants discussed budgets and financing in their own countries. In Germany there is a universal child benefit, and the discussion about whether this should just target the most vulnerable is controversial. In cases of separation, the state is trying to recuperate support payments to parents who are not the main carer and not paying alimony,– but it is only recovered from 6% of such

parents. The system is similar in France, but there is the possibility to take the money directly and the rate is higher at 62%. There is also website and phone line dedicated to separation.

## The Positive Parenting intervention in Spain

**Pilar Campos, Spanish Ministry of Health, Head of Health Promotion**

In  average life expectancy is high (82.3 years), but average healthy life expectancy is low (64.5 years). A national health promotion and prevention strategy, approved in 2013, aims to improve this by increasing healthy life expectancy by two years. Taking a life course approach, this strategy focuses on integrating and coordinating health promotion and prevention efforts across all levels, sectors, and stakeholders as well as and improving health and wellbeing by promoting healthy lifestyles and environments. It is set within an international framework which includes the sustainable development goals, Europe 2020, Health 2020, and WHO work on the control and prevention of NCDs. It covers three dimensions: three settings (Healthcare, school, municipality); six factors (physical activity, healthy diets, tobacco, alcohol, emotional wellbeing, and safety/injuries); and two prioritised populations – under 15s and over 50s.

Positive parenting is one of the five prioritised actions in the health promotion and prevention strategy. The overall goal is to promote health and wellbeing in children. The specific goals are

- To promote safe, non-violent upbringing, free of conflict environments for children.
- To promote children's social, emotional, language, intellectual, and behavioural abilities.
- To promote healthy lifestyles among children.

The Positive Parenting Policy was developed based on Council of Europe recommendations. It targets health professionals, and parents and caregivers. The recommendations cover:

- Services to support parents (local centres, training, helplines, services for vulnerable populations etc)
- Family policy measures: (secure adequate living standards, prevent children poverty providing high quality health care services.
- Awareness raising for parents (especially fathers) and professionals
- Mainstreaming children's rights in policy making

*Activities with citizens.*

An eight hour online parenting course has been developed for parents and caregivers. It focuses on improving health and wellbeing for children aged 0-3, and covers emotional attachment, nutrition, physical activity and play, and rest and sleep. Made available in January 2017, over 5,500 participants have taken the course..

Recommendations on physical activity, sedentary lifestyles, and screen time were published in 2015, adapted from WHO guidance. It includes recommendations for children aged 0-5.

A website about healthy lifestyles has been published, containing reliable information on topics such as physical activity and nutrition, tailored per age group.

*Activities in the health care setting.*

Online training and on-site activities have been provided for health professionals. There is an understanding that health professionals have an important role in helping parents understand their children's development, and that there is a need for continual professional development. Four editions of trainings for professionals have been developed and provided; 4066 people enrolled, 3341 people participated, and 2523 finished. About 50% of participants were nurses, whilst the rest were mostly doctors and midwives. The overall rating of the course was 8.6/10.

*Activities in the local setting*

Annual grants are available for local implementation of the positive parenting strategy. This year they amount to €1.66 million. The Spanish Network of Healthy Cities is supporting the implementation, as are the 261 local entities covering 40% of the Spanish population, which are signed up to the health promotion and prevention strategy.

One of the key areas of intervention is with Roma communities. This includes both providing training to professionals working with Roma populations, and providing a physical training course for Roma parents. Second hand smoke is a key concern; Roma children are five times more likely to be exposed than those from other populations.

*Challenges*

Five challenges have been identified:

1. Consolidating achievements
2. Comprehensive counselling about lifestyles in primary healthcare, linked to community resources the for the child population
3. Comprehensive counselling about lifestyles during pregnancy and breast-feeding
4. Including Positive Parenting in electronic health
5. Enhancing quality and a healthy start in life.

## Child and maternal protection centres (PMI): actor-contributor to social and health inequality reduction in local territories

**Manuela Cheviot and Agnès Vesse, PMI 93 Seine-Saint-Denis**

Child and maternal protection centres are actors/contributors to the reduction of social and geographical health inequalities. They were established after WWII to reduce child mortality and increase demographic development. Today their work to maintain and improve health is centred around three axes: child protection, maternal protection, and family planning. They offer two types of services (i) those to the public (infants, children, women, youths, and men), which includes consultations, vaccinations, collective prevention actions; (ii) those to professionals, including

professional training, particularly for nursery school assistants. The centres deal with a large public and a wide range of health issues. They take many different approaches: a good geographical spread (around 1-6 centres per town), a global approach, proportional universalism, a link between an individual and collective approach, and a multi-disciplinary approach. A wide variety of professionals are involved, including midwives, advocates, and psychologists.

Clichy-sous-Bois, the location of PMI93, is one of the most deprived communities in France. The average yearly income of families is €9,523; 58% of the population lives in poverty; 70% of the heads of households are foreign nationals; more than 25% of families are single parent families; and 1/6 of homes are over-occupied.

Children are over represented in the populations in vulnerable situations. Several specific problems concerning them have been identified. They show developmental delays such as language delays, problems with attention spans, and cognitive problems. Dietary issues are evident in levels of obesity and cavities. There are also periods of epidemics of tuberculosis and ringworms, and other diseases which are markers of social precariousness.

They key problems for families have been identified as: poor living conditions; life conditions which do not support the development of secure child – parent bonds such as social isolation and economic precariousness; elder siblings adopting a parental role and a distancing between families and institutions. Health inequalities manifest and have an impact from at a very young age, therefore relevant public policy need to be adapted to today's realities. Interventions need to be multi-faceted and local.

*The PEPPS project*

The PEPPS project is a multi-partner project, grouping the PMI, child psychologists, the town, social services, sanitary services, and the university. It is a research and action project, involving professionals and families. It is focused on children aged 0-3 and targets the most vulnerable families. It involves a multi-disciplinary team, the move towards more home visits and will aim to reinforce psycho-social skills. It was noted that there are already self-forming groups in the community, for example for childcare. It is important to work with these groups in the project's work.

## French WHO's Healthy Cities network

**Zoé Héritage, Director**

Thierry Cardoso (Santé Publique France) introduced the session by indicating that it is very important for the organisation to learn about how they can work as closely as possible to people. How can this be done?

The Healthy Cities movement is managed by WHO Europe and involves 1,400 cities and municipalities. 90 cities in France are involved. Politicians at city council and directors of public health apply a trans-sectoral approach to improve health, an extremely complex process.

Cities involved in the movement offer a range of services. In the city of Anger, for example, the focus is on supporting parents, specifically in priority neighbourhoods. The aim is to strengthen the parent/child bond and to enable parents to know where to get support. This is done through enjoyable activities, to build an network of professionals that can be used afterwards. In other cities the focus is on supporting childcare for families with anti-social working hours. Other cities are focusing on support for parents in school settings, by e.g. encouraging discussion and self-help groups amongst them, also involving teachers. There is a big focus in the Healthy Cities movement on identifying and sharing good examples of how municipal services can promote health, and there are many good things happening. Activities vary widely across cities and some have more capacities and resources than others to make things happen. There is ongoing work by the network on the theme of reducing health inequalities from the earliest age, involving activities like the exchange of best practice, a national conference and a book to be published (late 2018) on the topic.
The issue of access to vulnerable people was again raised: people who are poor often have anti-social working hours, making it difficult to reach them. In addition, people often do not want others to know they are poor.

### Discussion

It was noted that in some countries municipalities get extra funding if they become part of the healthy city network. UNICEF has an initiative on child-friendly cities, but there are no formal links between it and healthy cities; more between healthy and age-friendly city initiatives. The secretariat's funding is as follows: 45% is covered by members with payments depending on size. 60-65% comes from a grant from Santé Publique France, and a project on parks and green spaces. There are three full time salaried employees earning.

## Scotland's work to reduce childhood and adolescent health inequalities & WHO Europe collaborating centre on childhood and adolescent health: strengthening collaboration

**Eileen Scott, NHS Health Scotland**

Eileen described five strategic priorities:

- Fairer and healthier policy

- Children, young people and families
- Fair and inclusive economy
- Healthy and sustainable places
- Transforming public services

She noted that disparities in development equality translate into attainment inequality
In Scotland, two thirds of children facing poverty and social exclusion are in households where people work. Working doesn't protect households from poverty.

Scotland has a 'devolved' government, which means some powers have been transferred from the British government to the national Scottish legislature. The Scottish government can legislate around things that affect people's everyday lives, but does not have control over social-protection policy, which is developed at UK level.

Austerity measures have led to a reduction in benefits , and it is predicted that levels of poverty and social inclusion will continue to increase. It was noted that the impacts of deprivation get compounded. It's often the cumulation of all factors that result in health inequalities.

The results of Health Behaviours in School Aged Children report reflect that children generally do ok until the age of 11. By mid-adolescence however, scores linked to well-being plummet, particularly amongst girls.

In Scotland, there were 54 pieces of legislation related to child health and well-being. This led to confused landscape, with an overlap of resources and ineffective outcomes. Funds were often used on interventions that had no- or a weak evidence base.

Health and education are linked. To improve educational attainment, we need to focus on health. The government listened to the message that high quality education and health equity can have a big impact. The health sector therefore worked very closely with the education sector to establish common goals. The advantage of having a public health body involved was that it was impartial. Scotland is now investing one billion pounds on closing attainment gaps. Health and well-being is integrated in everything that children are learning. People responsible for curriculums and assessments are provided with an evidence review for this, and receive a briefing on the impact of the SDH on children's attainment. Schools receive extra money for deprived children. They are longer using this just to hire more teachers, but applying measures that have a real impact on health and well-being. This is a very strong example of how the health sector can collaborate with other sectors by showing how they are essentially aiming and advocating for the same thing.

Discussion focused on quality criteria for childcare and the health outcomes chosen, which centred around normal developmental milestones. It also focused on how to strengthen collaboration between participating organisations, to share approaches like these and evidence, in order to avoid overlapping resources. It is for example, very expensive to conduct systemic reviews. Eileen Scot presented on the WHO Collaborating Centre for Health Promotion and Public health Development, which focuses on child and adolescent health. It provides support to the WHO 'Investing in Children' Strategy (2015 -2020) and to Member States, as well as to the Health Behaviour in School Aged

Children Study and the WHO School Health Network.  It would be good to explore how to strengthen links between their and EuroHealthNet's work.

## Discussion: Conclusions from day two

During the final discussion, the importance of the local level in implementation was stressed. Issues around universalism and proportional universalism were discussed.

The group noted that parents are the most important partner

The work in Scotland was described as inspiring due to the links between health, wellbeing, and results

The group discussed how to strengthen links. They:

- Noted that we need to get better at sharing results and evidence-based practices, as well as sharing what doesn't work.
- Felt that further collaboration on areas of shared interest would be useful. A Technical Working Group (TWIG) on childhood could perhaps be created.
- Noted that violence against children and safety is an idea that appears across countries
- Would like to see how the WHO collaborating centre and the EuroHealthNet network can collaborate; a webinar may be useful
- Considered the utility of making more connections with the Alliance for Investing in Children.

The open EU Horizon 2020 Call on 'Implementation Research for Maternal and Child Health' was discussed. There was strong interest amongst many participants to respond, despite the relatively short time frame. It was noted that:

- There is a lot of scattered evidence to be collected.
- There is a need for more evaluation.
- Parenting is key, and fathers need to be included and involved too.
- More discussion on effective approaches to provide support in a non-stigmatising way are needed.

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