Report on 'Research findings Part II: Collection of key worldwide research articles that demonstrate effectiveness of policy solutions in the area early child health and development (0-3)'

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

Contents

Summary 5
1. Introduction 21
2. Basic concepts 25
3. Research approach 32
4. Limitations 35
5. Main findings 36
5.1. Access to healthcare services of children aged to 3, pregnant women and mothers 36
5.1.1. Access to prenatal care of uninsured pregnant women, living in poverty 36
5.1.2. Healthcare for new-borns through home visits by GPs or paediatricians 51
5.2. Services in support of opportunities for early learning and responsive caregiving 67
5.2.1. Home visiting national programs in support of responsive caregiving during the first 1 000 days of the child's development 67
5.2.2. Services in support of early learning of children aged to three 91
5.3. Access to services in support of secure and safe environments for children's development .. 107
5.3.1. Access to health and other public services of undocumented pregnant women and mothers of children up to age three 107
5.3.2. Community-based services in support of positive parenting in poor environment 134
5.4. ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line 155
6. Conclusions and recommendations 172
7. Annex 1 Coding trees 175
8. References 176

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Abbreviations

ANC – Antenatal care

ED – Emergency Department

ECD – Early childhood development

ECEC - Early childhood education and care

EHS - Early Head Start

ESDP - European Society for Developmental Psychology

EU – European Union

CDC – Centre for Disease Control

CCD – Care for child development

CHW – Community health worker

CHV -Community health volunteer

DM – Documented migrants

FC – Family Connects (program)

GP – General practitioner

HEW – Health extension worker

HBV – Hepatitis B virus

HIV/ACDC - Human immunodeficiency virus infection/Acquired immune deficiency syndrome

HKI - Helen Keller International

HV – Home visiting

ICDP - Integrated Community Development Program

IGL - Intergenerational learning

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IHN – In-home nursing

LHW - Lady, health, worker (program)

LMIC – Low and middle-income countries

MIECHV - Maternal, Infant, and Early Childhood Home Visiting (program)

NICU - Neonatal intensive care unit

NESS- National Evaluation of Sure Start

NFP – Nurse-Family Partnership (program)

NGO – Nongovernmental organisation

OSS - One Stop Service

PAMC – Potentially avoidable maternity complications

PDEP - Positive Discipline in Everyday Parenting

PICUM - Platform for International Cooperation on Undocumented Migrants

PNC – Postnatal care

ROR - Reach Out and Read

SSLP - Sure start local program

TOY -Together Old and Young

UM – Undocumented migrants

UK - United Kingdom

USA - United States of America

WIC - Women, infant, children

WHO – World Health Organisation

VIP - Video Interaction Project

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Summary

Introduction. Goals and tasks

This report is developed in the second phase of the research 'Development of methodology and implementation of research on policies for nurturing care of the child aged to 3 in Bulgaria, the European Union (EU) and other countries' for the Trust for Social Achievement.

The main goal of this research is to support the implementation of research-based advocacy for improvement of the process of planning and/or implementation of health and other health-related early childhood development (ECD) policies with direct impact on infant and maternal health outcomes of most excluded families and young children such as Roma communities in Bulgaria.

The specific objectives of this research are: to (1) equip stakeholders with knowledge on recent research findings so that they could initiate system changes for prevention and/or elimination of country-specific policy gaps for Bulgaria under the core policy areas of ECD: good health, adequate nutrition, security and safety, opportunities for early learning and secure and safe environment for the child's development; (2) to support the process of planning of ECD policies, programs, services and interventions, based on proved policy solutions, evaluated through impact assessment, which have rendered significant positive change or have demonstrated significant positive change through robust evaluation.

A number of international reports and documents, based on research data and evidence-based findings, confirm the significance of the early childhood stage for the child's subsequent development in all its aspects, including, notably their brain development and function from a neuroscience perspective.

The purpose of this collection is to provide necessary reference to stakeholders about the different policy solutions from Part I of the research: Collection and analyses of evidence-based practices for effective policy solutions, applied in EU Member States and other relevant countries for prevention and/or elimination of policy gaps. The stakeholders, towards whom this report is

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oriented, are participating in policy making and/or implementation processes such as governmental authorities, professionals, academic institutions, nongovernmental organisations (NGOs), etc.

The articles, selected in this II part of the research, support the policy solutions, identified as successful practices in the first part, but are also from countries outside of its scope. They are focused in the following policy areas, same as in the I part of the research: access to healthcare services of children aged to 3, pregnant women and mothers; services in support of opportunities for early learning and responsive caregiving; access to services in support of secure and safe environments for children's development; ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line.

Research approach

The research approach is based on a review and analysis of research articles, related to the areas of nurturing care, focal points of advocacy and oriented towards policies and programs whose effectiveness has been measured. The review is conducted through a selection of research articles and review articles in two stages and subsequent analysis of the articles.

The main criteria for selection of articles, which are applied, are: articles are directly related to identified evidence-based policy solutions from Part I of the research, whenever possible; articles include description of evidence of effectiveness; articles are published in peer-reviewed journals; research / original articles and review articles; articles are published in English and have not been translated in Bulgarian; full-text access.

The following steps are taken in order to conduct the analysis:

- Initial broad search of literature by keyword among scientific databases like Web of Science, Scopus, EbscoHost, Science Direct, Research gate;
- Further narrowing the search focus by applying relevant phrases, fragments of phrases and keywords from each subject area (i.e. focal point of advocacy);

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- Setting up inclusion and exclusion criteria for each subject area and evaluating the relevance of each study against those criteria;
- Determining the period of publication (1990-2020) to maximally expand the scope of the possible relevant findings;
- Minimizing research bias by applying double check to the set of selected articles in each subject area;
- Coding using NVivo 12 software, following an established criteria and coding procedure;
- Further analysis of data.

A coding tree, containing the most important codes, has been developed based on the first reviewed articles. It was used and completed subsequently, while the rest of the articles were coded and analysed. The main coding categories are demographics such as country, target group of the program, who conducted the research in the article, main problem, problem solution, research design and methodology, findings, and recommendations, etc.

Main findings

Access to healthcare services of children aged to 3, pregnant women and mothers

Access to prenatal care of uninsured pregnant women, living in poverty

Six research-based articles have been reviewed in this focal point of advocacy. The articles are not related to identified practices in the I part of the research, but rather present programs, related to the key problem and evidence-based solutions.

The main problems, targeted in most of the articles, relate to access to prenatal care and disparities in healthcare for vulnerable low-income and minority populations affected by the programs' implementation. All these articles follow the effects from the enrolment in the program in various directions: access, effectiveness, outcomes, cost consequences, regulatory framework development, associated with enrolment in the program. The problems, reviewed in

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the articles, are recognised at a national level and the barriers are related to vulnerable and low-income status of the target groups of the programs.

The **problem solutions**, identified in the articles, focus on two programs: **Medicaid**, which was initiated as a health-financing program for the welfare population, originally focused mainly on single mothers and their children eligible for welfare; the **Healthy Start** program, aiming to improve the quality of and access to health care for vulnerable, low-income, pregnant women by working with individual communities through outreach, health education, case management, and utilization of care.

Most of the studies are conducted based on **secondary data analysis**, since there is available data in the target country – USA. The study design is mostly comparative, longitudinal, and cost consequence.

The **findings** of the articles are the following: poverty, lack of social support, the presence of diabetes, and living in a rural county are the underlying factors for some racial disparities in avoidable pregnancy morbidity; presumptive eligibility has increased the proportion of women who enrolled in **Medicaid** during the first trimester and is successful in reducing the proportion of women who fail to begin prenatal care in the first trimester, the proportion who obtain inadequate care, and the proportion who delay obtaining care until the third trimester or fail to get any care at all; birth outcomes have improved over the study period for low-income women without private insurance and statistically significant reductions have been found in the number of low-birthweight babies and in the number of infant deaths; reduction in the number of low birth weight babies and related neonatal complications leads to both short- and long-term cost savings. The findings in the study of the **Healthy Start** program show that enrolment in the study agency results in much better outcomes in terms of birth weight than the city population as a whole.

According to the **recommendations** of the articles, given examples of policies and programs intended to provide access to health care and prenatal care for uninsured, low-income, pregnant women, in particular, demonstrate that the latter is a matter of national priority. It should be

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noted that currently all pregnant women who have income below 138 percent of the poverty line are among the so called 'mandatory' populations covered by Medicaid. Evidence shows that initiatives such as Healthy Start could improve access to health care of vulnerable, low-income, pregnant women. It is also a matter of national priority. Depending on the context, some outreach strategies (liaison workers) proved to be more cost-effective than others.

Healthcare for new-borns through home visits by GPs or paediatricians

Nine research-based articles have been reviewed in this focal point of advocacy. All of these articles present different models for home visits, they are not related to the I part of the research direct, but they upgrade information about the topic.

The problems tackled in the articles relate to access, provision and quality of maternal and new-born care and are significant. They are widely recognized by both international organizations, such as WHO, UNICEF, the World Bank, and national governments. Many practices are introduced to reduce the maternal and infant morbidity and mortality and promote healthy behaviours. A number of studies demonstrate that home visits by trained CHWs can change new-born care practices.

Problem solutions derived from the studies could be summarized in three main directions: home visits provided by health extension visitors/ CHWs/ volunteers/ nurses/ GPs and/or paediatricians; programs to improve maternal and new-born care, such as a group-based health education and microfinance program and telephone support in addition to home visits for preterm infants; maternity waiting homes as a means to provide a continuum of care in remote areas. The main problem solutions in this area are the programs **Chamas for change, Save the Children's Saving Newborn Lives and Baby Bridge**.

Most of the **study design and methodological approaches** explored primarily quantitative methods by administering questionnaires either directly or online. One article presents a qualitative study that uses the philosophical hermeneutics as a method for data analysis. There is also a review article, based on the scoping review framework.

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The findings of the studies in this area relate to the main programs**.** A significantly higher proportion of **Chamas for change** participants delivered in a health facility; experienced a lower proportion of stillbirths, miscarriages, infant and maternal deaths; promotion of other positive MNCH behaviours. A positive association between **maternity waiting homes** use and number of ANC visits, attending all PNC visits, increased contraceptive use of any kind to avoid pregnancy. The study on **community health workers** shows that there are statistically significant improvements in breastfeeding, cord care, thermal care in different cultural settings; community health workers' greatest impact is in areas with high rates of home delivery predicts ensuring new-born care practices. **Home visits & telephone support I**ncreased care opportunities and may prevent further complications in situations of prematurity. The **Baby Bridge Program** is cost-effective and achieved sustainability within 16 months of implementation. The study on **Save the Children's Saving Newborn Lives** found that home visits by community health workers during pregnancy can play a role in improving practices in different cultural settings; the impact of home visit programmes on new-born care practices may be greatest in areas with high rates of home delivery; facility delivery is the most important predictor for ensuring new-born care practices.

According to the **recommendations**, policies, and programs subject to the articles are examples that illustrate the role of the investments in community-based strategies to improve access to healthcare for mothers and new-borns in disadvantaged areas. Various practices exist and are successfully implemented depending on the cultural context and national specifics. They include involvement of paraprofessionals or trained people from the community, not necessarily professionals such as nurses or paediatricians.

Services in support of opportunities for early learning and responsive caregiving

Home visiting national programs in support of responsive caregiving during the first 1 000 days of the child's development

Eight research-based articles were reviewed in this focal point of advocacy. One of them is related directly to the first report in this research (part I) –the Home Start program, the rest upgrade

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information from the I part with many more HV programs (mainly in the USA, as well as internationally acclaimed and implemented programs).

The **main problems**, targeted in most of the articles, relate to the areas of healthcare and parenting, such as punitive parenting behaviour, health disparities experienced by underserved and disadvantaged populations, elevated risk for poor physical or developmental outcomes, elevated risk of failing to achieve human potential, inadequate nutrition and frequent illness contributing to stunted growth, family-level risk factors, parental stress and risk of mental health problems, childhood psychological and behavioural problems, child abuse and neglect, lack of proper PNC, etc. In addition, according to the evidence base in most of the articles, research on HV is either scarce in general or certain aspects have not been studied sufficiently.

The **problem solutions** are several home visiting programs that have a wide national/international scope and there is evidence regarding their effectiveness and impact. These are **Home Start, Care for Child Development, First Born, Family Connects, Nurse-Family Partnership, Maternal, Infant, and Early Childhood Home Visiting program.**

Most researchers have employed a quantitative methodology, mostly secondary data analysis, but also randomized control trials and questionnaires. This means that sometimes **the design** is experimental and other – not. Some researchers have also employed a qualitative methodology, such as interviews and observations, as well as a mixed method approach with both quantitative and qualitative methods.

The **findings** of the articles show that **Home Start** leads to significant improvement in perceived parenting competence. There are no effects on maternal depressive moods and no changes in child behaviour. The **Care for Child development** interventions can improve child development, growth and health, as well as responsive caregiving. They lead to reduced maternal depression, a known risk factor for poor pregnancy outcomes and poor child health, growth and development. Findings about the **First Born** program show that children are one-third less likely to visit the ED in their first year of life and 41% less likely to have visited a primary care provider more than 9 times. The program reduced infant health care use for high-risk and lower-risk

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families. According to another article, focused on **home-based early intervention with families of children with disabilities,** the content of home visits is more likely to focus on the child when family resources are adequate, and the role of the interventionist is more likely to be that of an observer when children have greater care-taking demands. The article regarding the **Maternal, Infant, and Early Childhood Home Visiting** focuses on the at-risk families' access to three home visiting programs, among which is the Nurse – Family Partnership program. According to the findings, children with greater needs are more likely to receive HV services. In addition, mothers who live in communities that have a higher proportion of residents that did not finish high school demonstrated relatively higher program engagement. The **Family Connects** program has penetration in a high proportion of population and high quality. The primary outcomes are: child protective services investigations for maltreatment, more community connections, fewer cases of maternal anxiety or depression and fewer investigations for child abuse. All mothers in the research responded that the program was helpful.

According to the **recommendations** in the articles, there is a big variety of HV programs and they generally centre around the following: expand implementation of CCD services for at-risk families; well-designed evaluation to formulate the optimal home visits; proactive outreach and recruitment strategies; use a staffing model in home-visiting that does not rely exclusively on nurses; use of monitoring findings to support HV programs; increasing the HV services available in the continuum of services; funds should be allocated to state with more children at greater need.

Services in support of early learning of children aged to three

Ten research-based articles were reviewed in the focal advocacy point services in support of early learning of children aged to three. Some of the articles are related to identified practices from the I part of the research as Sure start, Home start, Toys for inclusion, Community mothers, etc., as well as additional practices related to this focal point of advocacy.

The **problems**, reviewed in the articles, are related to intergenerational transmission of inequity, disadvantaged children in rural areas, parental overwhelming and child rearing. In general, the

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issues in these articles are related to problems in the families and parental upbringing, which is probably due to the age of the children (0-3), when children are mostly looked after in a family environment. Therefore, the wellbeing of the parents directly affects children's wellbeing.

The **problem solutions** are several evidence-based programs, targeted and studied in the selected articles: **Community Mothers**, **Sure Start UK, Toybox Ireland, Abecederian Project**.

The main characteristics of the **study designs and methodologies** of the articles are that the targeted programs have their own monitoring systems. Both qualitative and quantitative information have been collected. Usually, quasi-experimental design has been used in order to evaluate the level of effectiveness and impact.

The **findings** regarding the **Sure Start program** show that it leads to improved parental capacities and active involvement of parents; improved self-esteem, job seeking, self-confidence and parent's relationship with their children. The **Early Head Start program has a s**trong impact of centre-based provision, strong effect for moderate risk families, greater effects when families are enrolled in the program earlier, as well as an effect on parenting practices and children's development. The **Community mothers** program has an effect on confidence, effect on self-esteem, effect on sense of calm and security, impact of parenting abilities. The **Abecederian project has** effects on children's progress at school and university over time; reduced incidence of delayed cognitive development; the most vulnerable children benefit from the program the most. The **Home-Start program** usage leads to increased well-being and perceived competence of mothers; parental consistency and observed sensitivity improved significantly.

According to **recommendations** in the articles, while focusing on parenting is important, it is also necessary to address the conditions of daily life, which makes positive parenting difficult. This requires policies aimed at children through an explicit, multi-dimensional and integrated strategy and investment in reducing child poverty and improved living conditions. it is important to provide access to a comprehensive range of quality early year services in order to reduce inequalities during the early development of children, especially for those from disadvantaged backgrounds.

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Access to services in support of secure and safe environments for children's development

Access to health and other public services of undocumented pregnant women and mothers of children up to age three

Ten research-based articles have been reviewed in this focal point of advocacy. These articles add to and upgrade the information from the I part of the research, related to undocumented women.

The analysed articles study access to and quality of healthcare services for undocumented pregnant women and mothers of children up to age three within the broader context of policies and practices concerning the right to health for all. Specific **problems**, related to both structural barriers and personal experiences, are largely discussed. In some of the articles, the focus is put on national policies and international initiatives to 'leave no one behind', such as policy approaches regarding access to care for UMs regardless of the legal status and the UN initiative for introducing digital identification system.

In this focal point of advocacy, there are no specific programs identified as **problem solutions**. However, they focus on different aspects of the solution of the problem with undocumented pregnant women and mothers: provision of equal and equitable access regardless of the status, challenge the status of illegality, focus on intercultural competence and language interpreters, safe and accessible screening services for pregnant UM women.

Studies differ in **design and methodological approaches** applied to the problems under investigation. They could be grouped into the two common categories of primarily quantitative and primarily qualitative research, although some of them are based on mixed methods approach. It is of notice that most of the articles under analysis explored either qualitative or mixed methods framework, which could be explained by the purpose and the necessity to provide an in-depth understanding of the migration-related phenomena.

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There are **various findings** showing that access to care for undocumented pregnant women is shaped by serious structural, institutional, and moral issues. These findings in the articles concern late presentation to screening for infectious diseases; late booking or registration of pregnancy for antenatal care; high prevalence of unintended pregnancies and abortions; lower access to pregnancy screening; higher prevalence of HBV infections.

There are several **recommendations** made to overcome the problems identifies and examined in the articles. A systematic access to prenatal care is proposed to include all pregnant UM women in routine pregnancy screening programs. This will lead to earlier presentation to health care services and improve screening coverage for preventable infectious diseases to protect the child from vertical transmission with HIV, HBV, and syphilis. There is a need, at the societal and institutional levels, to redress the idea of healthcare as a right and not a privilege by providing accurate information about the rights of migrants with precarious status, their genuine position in the global marketplace, and the vulnerability of their health, and by creating a safe space for discussions.

Community-based services in support of positive parenting in poor environment

Ten research-based articles have been reviewed in this focal point of advocacy. Some of the articles are related to identified practices from the I part of the research. Among them is the Triple P program, as well as a number of other group programs for development of parental skills.

The analysed articles study specific **problems** in terms of effects from programs for development of parental skills for positive parenting and violence prevention or ways to change paediatric practices or policies. In some of the articles, concrete recommendations regarding development of programs and services are discussed.

The **problem solutions**, studied in the articles are specific programs, developed to support positive parenting in poor environment. They focus on group programs for positive parenting, individual type of programs, combined programs, different software tools, etc. The main characteristics of these group decisions are a multidisciplinary approach and combining the

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efforts of different professional – health, social and educational to develop the skills of beneficiaries for positive parenting. The studied programs are: **Positive Discipline in Everyday Parenting, Healthy Steps, Triple P and Rise Up**.

The **study design and methodology** of the reviewed studies have several general characteristics. Mainly quantitative data is collected, with experimental or quasi-experimental design. Many instruments for data collection have been employed, among which are scales for measuring parental competence – lifestyle evaluations, preschool evaluations, etc.

The findings regarding the **Rise Up program** point to the fact that parents and professionals describe different changes in parents' parenting skills, stress, and social support after participation in the PSP, and in their children's behaviours. In the **Triple P** program, parents reported significant reductions in dysfunctional parenting behaviour, and mothers also reported an increase in positive parenting behaviour. In addition, mothers reported significant reductions in internalizing and externalizing child behaviour. The **Healthy Steps** program shows significant positive aggregate effect for primary care–delivered interventions on parent-child interactions. Higher percentage of parents reported following routines and using less severe discipline. Many of the studies included in this review evaluated the impact of the intervention on early childhood language development. The effects of the **Positive Discipline in Everyday Parenting** are that parents are mostly or very satisfied with the program, the materials and activities provided. The majority of parents beneficiaries of the program said that it has a positive impact on their parenting skills and abilities. They shared that the program 'helped them to understand their children's development and feelings, communicate better with their children, control their anger, and build stronger relationships. According to findings about the **Parenting Program in Spain,** participants improved their parenting skills and levels of social support, children's negative behaviours parental stress were reduced. All outcomes maintained this significant improvement. Parents and professionals describe different changes in parents' parenting skills, stress, and social support after participation in the PSP, and in their children's behaviours.

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In terms of **recommendations**, the topic of positive parenting is quite actively appearing and commented on in the last years in relation to ensuring a safe and secure environment for raising and supporting children in their development. The development of parental skills, in spite of being a part of different programs for HV, is also supported by programs, focused directly on positive parenting in the best interest of the child. The studies of different programs related to positive parenting should be continued. It is also necessary to develop new evidence base for policy making, in order to support the effort of ensuring a safe and secure environment for children's development.

ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line

Sixteen articles have been reviewed in this area. Four of the articles are related to practices from the first part of the study: Healthy Start, implemented in the UK and WIC (women, infants, children), implemented in USA.

The **problems**, reviewed in the articles, are related to nutrition, and feeding issues, malnutrition, poor dietary practices, nutritional inequalities, difficulties to prioritize healthy food, inadequate feeding, nutritional deficiencies during pregnancy, challenges to maintain a healthy diet, nutritional interventions, nutrition in the first years, breastfeeding, introduction of solid food, food insecurity. Single interventions targeting ECD or nutrition can be effective, but there is limited evidence regarding the development, implementation, evaluation, and scaling up of integrated interventions.

The **problem solutions** are oriented towards four main areas: nutritional - food packages, which could be vouchers, packages, or money; educational – development of knowledge and skills; programs containing different components – nutritional and educational; integrated programs/nutritional specific and nutritional sensitive programs. The programs, targeted in the articles, are: **Women, Infants and Children, Healthy Start, Progresa and Hellen Keller International's Enhanced Homestead Food Production**.

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In most of the research projects conducted, quantitative **methods** are used, since in general in countries, such as the USA, this is considered a valid approach, providing possibility for a bigger scope of the study. Some of the studies are longitudinal, in order to see what the impact of the program is in the long-term, regarding children's development. Some of the studies have an experimental design, while others have a quasi-experimental design. The methods are mainly surveying, secondary data analysis. Four articles are reviews of policies and practices, which consists of examples of quantitative research.

The **findings** in the articles can be grouped in the following way: infants and family benefit from the programs; implications on policy and practices; increase in parents' knowledge. Some of the findings relate to cost effectiveness and cost benefit of the programs, combining responsible stimulation and nutrition.

In general, in some of the articles improvement of the programs is **recommended**, concerning access, process of delivery, raising awareness, etc. Other recommendations are related to the policy level and effective partnership. All sectors, public and private, need to form effective partnerships and do their part to deliver quality services to disadvantaged populations. Additionally, more research is necessary on the cost effectiveness of the program.

Conclusions

Access to healthcare services of children aged to 3, pregnant women and mothers

Identified evidence-based practices in countries with a similar socioeconomic profile show that access to prenatal care is ensured for all pregnant women; visits at the homes of families with new-borns happen usually as a part of HV services.

Identified solutions in the research articles show that the evidence base confirms that equal access is ensured since it is a national priority. Various practices have been identified, which are successfully implemented, depending on the national context, and include the involvement of paraprofessionals or trained people from the community.

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Services in support of opportunities for early learning and responsive caregiving

Identified evidence-based practices in countries with a similar socioeconomic profile show that there is a big variety of HV services - universal, as well as targeted towards vulnerable communities; early learning services are usually integrated and a part of group and individual programs.

Identified solutions in the research articles show that the evidence base confirms the effectiveness of the HV programs and those for early learning.

Access to services in support of secure and safe environments for children's development

Identified evidence-based practices in countries with a similar socioeconomic profile show that practices are specific and related to solving concrete problems of vulnerable groups without personal documents; a universal program for development of parental skills has also been identified.

Identified solutions in the research articles show that the problem with undocumented people is viewed in terms of different solutions for health system access and statelessness; there is a variety of highly effective positive parenting programs.

ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line

Identified evidence-based practices in countries with a similar socioeconomic profile show that practices are integrated, they include food provision and development of parental skills for feeding, high quality food, etc.

Identified solutions in the research articles show that there needs to be such services, but they depend on the local context and poverty.

Recommendations

Access to healthcare services of children aged to 3, pregnant women and mothers

- Change in the legislation to ensure equal access to prenatal care for all pregnant women;

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- Creation of a national HV system of services.

Services in support of opportunities for early learning and responsive caregiving

- An HV system should be developed and implemented. It should have different components - universal and targeted;
- A methodology of the service should be developed, including different components, among which early learning should be central.

Access to services in support of secure and safe environments for children's development

- There needs to be a change in the legislation in terms of access of undocumented people to health and other services;
- Development and implementation of programs for positive parenting in different forms.

ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line

- Development of a program, which combines nutritional support and development of parenting skills. The local context needs to be taken into account when developing this program.

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1. Introduction

This report is developed in the second phase of the research 'Development of methodology and implementation of research on policies for nurturing care of the child aged to 3 in Bulgaria, the European Union (EU) and other countries' for the Trust for Social Achievement.

A number of international reports and documents, based on research data and evidence-based findings, confirm the significance of the early childhood stage for the child's subsequent development in all its aspects, including, notably their brain development and function from a neuroscience perspective.

The main goal of this research is to support the implementation of research-based advocacy for improvement of the process of planning and/or implementation of health and other health-related early childhood development (ECD) policies with direct impact on infant and maternal health outcomes of most excluded families and young children such as Roma communities in Bulgaria.

The specific objectives of this research are: to (1) equip stakeholders with knowledge on recent research findings so that they could initiate system changes for prevention and/or elimination of country-specific policy gaps for Bulgaria under the core policy areas of ECD: good health, adequate nutrition, security and safety, opportunities for early learning and secure and safe environment for the child's development; (2) to support the process of planning of ECD policies, programs, services and interventions, based on proved policy solutions, evaluated through impact assessment, which have rendered significant positive change or have demonstrated significant positive change through robust evaluation.

A number of international reports and documents, based on research data and evidence-based findings, confirm the significance of the early childhood stage for the child's subsequent development in all its aspects, including, notably their brain development and function from a neuroscience perspective. *'The period from pregnancy to age 3 is when children are most susceptible to environmental influences. That period lays the foundation for health, well-being,*

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learning and productivity throughout a person's whole life, and has an impact on the health and well-being of the next generation.'[1]

In the 'Quality framework for Early Childhood Practice in Services for Children under Three Years of Age' it is stated that the early years of children's lives are a period, in which children are especially vulnerable, but also there is great opportunity for development. *'Countries must provide structural and process quality in all early childhood services working with this age group. There are compelling reasons for asking governments to focus on quality in services for all young children.'*[2] Among the main reasons are indicated some of the following*: 'this provision is a fundamental human right of every child, as outlined in the United Nations Convention on the Rights of the Child (UNCRC); there is a growing number of children under three years of age in out-of-home services; there is greater evidence that positive parenting at this age can significantly affect the child's health, development, and learning throughout their life, so support provided to parents through home visiting and early childhood services is of great importance; early-years experiences, especially in the first three years of life, lay the foundation that shapes children's future health, happiness, growth, development and learning achievement at school, in the family and community, and throughout life; investments in services for young children reduce the risk of child abuse and neglect to a greater extent than treatment services; the importance of providing quality services specifically for children under three is underpinned by communications from multiple scientific bodies, including those from neuroscience, developmental psychology, education and other disciplines. It shows that the specific experiences of a child under three have the profound effect of limiting or expanding their social, physical and cognitive potential.'*[3]

There is vast economic evidence indicating investment in ECD is a smart investment that has a huge return to the general society from a cost-benefit perspective. '*Investing in early childhood*

[1] WHO, United Nations Children's Fund, World Bank Group (2018). Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva, 2018. Licence: CC BY-NC-SA 3.0 IGO. retrieved from: https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf

[2] International Step by Step Association (2016) A QUALITY FRAMEWORK for Early Childhood Practice in Services for Children under Three Years of Age, retrieved from: https://www.issa.nl/sites/default/files/pdf/epubs/ISSA_Quality_Framework_0-3/PDF/ISSA_Quality_Framework_0-3_e-version_screen.pdf

[3] Ibid

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development is good for everyone – governments, businesses, communities, parents and caregivers, and most of all, babies and young children. It is also the right thing to do, helping every child realize the right to survive and thrive. And investing in ECD is cost effective: For every $1 spent on early childhood development interventions, the return on investment can be as high as $13. Early childhood development is also key to upholding the right of every child to survive and thrive'[4].

Additionally, the term nurturing care is central and includes all aspects of ECD in its importance.

'Enabling young children to achieve their full developmental potential is a human right and a critical requisite for sustainable development. Evidence in the Lancet series Advancing early childhood development: from science to scale (Black, 2017) highlights the profound benefits of investing in ECD for learning, productivity, health and social cohesion along the life course. The series highlighted the critical importance of the early years and coined the term 'nurturing care' as a central tenet of what is required to achieve optimal development, namely health, nutrition, security and safety, responsive caregiving and opportunities for early learning'. [5]

The purpose of this collection is to provide necessary reference to stakeholders about the different policy solutions from Part I of the research: Collection and analyses of evidence-based practices for effective policy solutions, applied in EU Member States and other relevant countries for prevention and/or elimination of policy gaps. The stakeholders, towards whom this report is oriented, are participating in policy making and/or implementation processes such as governmental authorities, professionals, academic institutions, nongovernmental organisations (NGOs), etc.

The analysis of evidence-based practices for nurturing care for children up to 3 years old from part I presents different policy solutions for ensuring access to services for vulnerable groups,

[4] Ibid
[5] World Health Organization. (2020) Improving early childhood development: WHO guideline. Geneva: Licence: CC BY-NC-SA 3.0 IGO, retrieved from: https://www.who.int/publications/i/item/97892400020986

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children aged to 3 and mothers in countries with a similar socio-economic profile to Bulgaria, mostly in the EU, in the following policy areas:

- Access to healthcare services of children aged to 3, pregnant women and mothers: the identified policy solutions are from the countries Croatia, Slovenia, and Estonia. The evidence-based practices in Croatia and Estonia are related to introduction of regulations and financing at a national level for guarantying equal access to care for all pregnant women, regardless of whether they have health insurance. Additionally, a good practice, regarding home visiting (HV) services by health specialists and nurses for families with new-borns on a national base, was identified in Slovenia.
- Services in support of opportunities for early learning and responsive caregiving: the identified policy solutions include several international and widely recognised programs: the Home Start program, the Sure Start program (with a particular focus on the Hungarian Sure Start Children Houses program) and the Toy for inclusion program. In addition, a practice of HV in North Macedonia is identified, including universal, targeted, and intensive support.
- Access to services in support of secure and safe environments for children's development: the identified policy solutions are from the countries North Macedonia, Serbia, and Croatia. In North Macedonia, the government has taken actions in relation to solutions for Roma people without citizenship and identity documents. One of the evidence-based practices in Serbia is related to ensuring access to civil and socio-economic rights of vulnerable groups, including Roma people. The other Serbian good practice is a program, aiming to facilitate the development of stimulating and safe family conditions for young children from Roma families. In addition, the practice in Croatia involves community services to support positive parenting.
- ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line: the identified policy solutions are from the countries Romania and Hungary. In Romania, an integrated model of ECD

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services and food programs for vulnerable families with young children living below the poverty line, was identified. Furthermore, in Hungary, free food is provided to children, living in poor areas.

The analysis of evidence-based practices also includes successful models from the Netherlands, Ireland, and Sweden in all of the components of nurturing care, among which are HV programs, program for individual development and evaluation of the new-born, as well as the programs 'Community Mothers', 'Theraplay', 'Incredible years' and 'Triple P', related to development of parental skills and community support for families with children at a young age.

The II part of the research is a result of an effort to identify scientific proof concerning some of the identified practices in the first research, to enlarge the scope of evidence from scientific research articles, which provide a solid basis for policy recommendations, as well as to present new practices from additional countries. Therefore, the articles, selected in this II part of the research, support the policy solutions, identified as successful practices in the first part, but are also from countries outside of its scope: **in Europe:** United Kingdom (UK), The Netherlands, North Ireland, Czech Republic, France, Spain, Germany, Denmark, Switzerland, Italy, Spain, Greece, Nordic countries; **in North America**: United States of America (USA), Canada, Mexico, Costa Rica; **in South America**: Brazil; **in Africa:** Zambia, Kenya, Ethiopia, Malawi, Uganda; **in Australia**: Australia and Pacific region islands; **in Asia**: China, Nepal, Bangladesh, Pakistan, India; as well as **other various South American and Asian countries**.

2. Basic concepts

The following basic concepts and definitions are used in the process of identification of successful practices and scientific research, which provides evidence-based information about their effectiveness:

- **Early Childhood Development (ECD):** encompasses physical, socio-emotional, cognitive and motor development between 0-8 years of age (European Commission, 2019). This period requires a continuum of intersectional interventions for children, their parents and caregivers in

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order to safeguard and maximize children's developmental outcomes. (UNICEF, 2001) (World Bank, 2013).

- **Early Childhood Education and Care (ECEC):** ECEC refers to any regulated arrangement that provides education and care for children from birth to compulsory primary school age, which may vary across the EU. It includes centre and family-day care, privately and publicly funded provision, pre-school and pre-primary provision (European Commission, 2014).

- **Framework for Nurturing Care:** The framework is based on the most recent evidence about child development and about the effective policies and interventions that can improve ECD. Its main components are: good health, adequate nutrition, responsive caregiving, opportunities for early learning, security and safety (WHO, 2018).

- **Access to ECEC:** A family is considered to have 'access' to ECEC when a place is available or can be made available in a quality ECEC setting where neither distance nor cost presents a barrier to attendance (European Commission, 2014). European quality framework emphases that that the provision that is not only available and affordable to all families but encourages participation, strengthens social inclusion, and embraces diversity.

- **Child-centred pedagogy including the interest of the child**. A child centred approach is one which builds on children's needs, interests and experiences. These include cognitive, social, emotional and physical needs. A child centred approach is one that uses a pedagogy which promotes children's holistic development and enables adults to guide and support their development (European Commission, 2014).

- **Comprehensive service** is one that extends beyond the provision of ECEC and includes a cooperative approach with other services to focus on all other aspects of children's development such as their general health and well-being, child protection and support for them and their parents in their home and community environments (European Commission, 2014).

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- **Holistic approach** ECEC is child-centred and means paying attention simultaneously to all aspects of a child's development, well-being and learning needs including those which relate to social, emotional, physical, linguistic and cognitive development (European Commission, 2014).

- **Evidence-based practice** in social science promotes more effective social interventions by encouraging the conscientious, judicious, and explicit use of the best available scientific evidence in professional decision making (Zarghi, & Khorasani, 2018). According to the American Council on Social Work Education[6], citing scientific evidence (Sackett et al., 1996, p.71), there are five important steps involved in any evidence-based practice model: formulating a client, community, or policy-related question; systematically searching the literature; appraising findings for quality and applicability; applying these findings and considerations in practice; evaluating the results.

- **Integrated systems** refer to a coordinated policy for children where related care and education services or systems work together. In this context other services such as social welfare, schools, the family, employment and health services can also collaborate to support children in an ECEC context. When all ECEC services for children are integrated, this is usually described as comprehensive provision. Collaboration includes a close working relationship for those with administrative responsibility for providing ECEC services at a national, regional and/or local level (Zarghi, & Khorasani, 2018).

- **Outcomes from provision of ECEC services** are the actual or intended short-term and long-term changes arising from the provision of ECEC services that will benefit children, their families, communities and society. These changes are measurable and the benefits for children typically include: the acquisition of cognitive skills and competences; the acquisition of non-cognitive skills and competences; the successful transition to school; participation in society and preparation for later life and citizenship (Zarghi, & Khorasani, 2018).

- **Quality Framework for Early Childhood Practice in Services for Children under Three Years of Age** is grounded in the Convention on the Rights of the Child and stands for the centrality

[6] https://www.cswe.org/Centers-Initiatives/Initiatives/Teaching-Evidence-Based-Practice

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of the child and family in conceptualizing, designing and implementing programs dedicated to this age group, no matter the type of service, program, or sector. It comprises 31 principles and 143 recommended practices, grouped around 9 Focus Areas, thus covering the complexity of the practices and responsibilities that binds all professionals working in early childhood services. Relationships; Family and Community; Inclusion, Diversity and Values of Democracy; Health, Well-Being and Nutrition; Development and Learning; Observation, Documentation, Reflection and Planning; Enabling Environments; Professional Development; Intersectoral Cooperation (ISSA. 2016).

- **Family-centred service delivery** – Family-centred service delivery, across disciplines and settings, recognizes the centrality of the family in the lives of individuals. It is guided by fully informed choices made by the family and focuses upon the strengths and capabilities of these families. The definition emphasizes three core elements of family-centred practice: the family as the unit of attention, informed choice, and a strengths perspective (Petr, 2003).

- **Responsive feeding** – 'to feed the infant directly and assist older children when they already eat on their own; feed them slowly and patiently, and encourage children to eat but do not force them; if the child refuses many types of foods, experiment with different food combinations, tastes, textures, and methods of encouragement; minimize distractions during meals; and make the meals an opportunity for learning and love, talking to the child during feeding and maintaining eye contact' (Silva et al, 2016)

- **Unresponsive feeding interactions** – 'Unresponsive feeding interactions, characterized by negative, coercive strategies to encourage children to eat or by permissive, overindulgent strategies, such as providing frequent snack foods with low nutritional quality, may compromise children's feeding behaviour, leading to them being either underweight or overweight' (Schwartz, C. et al. 2011 in Black et al.)

- **Stunting** – 'Stunting (height-for-age z score < 22, based on the WHO growth standard) is an indicator of chronic undernutrition'. (Maureen M Black et al. 2015) 'Stunting early in life has been associated with consequences that threaten equity throughout the life span, including

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delayed school entry, early school termination, and poor school performance, resulting in reduced work capacity and human capital.' (Hoddinott, J. et al. 2013 in Black, M. M., & Dewey, K. G). 'Early stunting has been used as an indicator, along with poverty, to estimate the number of children worldwide who do not reach their developmental potential' (Grantham-McGregor, S. et al. 2007 in Black, M. M., & Dewey, K. G)

- **Food security** - includes availability, economic access and use of food, feeding and caregiving resources and practices (including maternal, household and community levels) and access to and use of health services, as well as a safe and hygienic environment (i.e. food, care and health) as key determinants of optimal child nutrition, growth and development '(Black et al. 2013 in Haselow et al.)

- **Nutrition specific interventions** – 'Nutrition specific interventions regarding the availability, accessibility, and acceptability of food and nutrients, beginning before conception and extending to breastfeeding promotion, the timing of complementary feeding, and dietary adequacy during childhood' (Bhutta, Z.A. et al. 2013 in Black, M. M., & Dewey, K. G)

- **Nutrition-sensitive interventions** – 'Nutrition sensitive interventions have emerged from the recognition that nutritional status is affected by factors that extend from societal conditions, such as poverty alleviation and women's empowerment, to household considerations, such as mealtime organization and family feeding interactions. (Ruel, M.T. & H. Alderman. 2013 in Black, M. M., & Dewey, K. G)

- **Intergenerational learning (IGL)** involves different age groups learning together or learning from each other in a range of settings. It is actually the oldest method of learning, whereby knowledge, skills, values, and norms are transmitted among generations, typically through the family (Cortellesi, G., & Kernan, 2016)

- **Positive parenting** is defined as 'parental behaviour based on the best interest of the child that is nurturing, empowering, non-violent and provides recognition and guidance which involves setting of boundaries to enable the full development of the child' (Vázquez Álvarez, 2017, p. 11)

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- **Resilience** is a dynamic process of positive adaptation to or despite significant adversities Others have identified resilience as the ability not just to bounce back, but to ''bounce forward'' achieved through the give and take of safe, stable, nurturing relationships that are continuous over time (attachment), and in the developmental growth, that occurs through play, exploration and exposure to a variety of routine activities and resources (building skills).This staircase model provides a conceptual framework for the process by which we are most resilient (Svendsen at all. 2020, p.21)

- **Attachment relationship** of child to caregiver begins at birth as the infant makes eye contact, hears the voices, and is fed and held by an attentive caregiver. In healthy relationships, the caregiver responds by providing empathy appropriate to the distress and needs of the child. Another way of explaining what the caregiver does is ''attunement,'' which most literally means ''bringing into harmony'' (Svendsen at all 2020, p. 18)

- **Equal and equitable access to healthcare** – in the sphere of public health this concept distinguishes between equality of opportunities and equality of outcomes. While equality means giving everyone the same thing, equity means giving people what they need to reach their best health. Access to equitable health care means that all individuals have access to quality care - health care, which is safe, effective, timely, efficient, equitable, and people- centred. Understanding the difference between equity and equality is a key component in the effort to reduce health disparities among vulnerable populations.

- **Quality of maternal, new born and child health** (MNCH) care – According to WHO and UNICEF, this concept refers to 'the degree to which maternal and new born health services (for individuals and populations) increase the likelihood of timely, appropriate care for the purpose of achieving desired outcomes that are both consistent with current professional knowledge and take into account the preferences and aspirations of individual women and their families' (WHO, 2020)

- **Undocumented migrants (UMs)** – according to UNCHR the most comprehensive text on international migration adopted by the international community at the time affirmed that

undocumented or irregular migrants are persons who do not fulfil the requirements established by the country of destination to enter, stay or exercise an economic activity

- **Fidelity -** the process of aligning program operations or actions to the specified procedures of the specific model being used. Programs show fidelity to a model when they are implementing as expected and as outlined by the creators of the intervention, often articulated in an implementation manual (Korfmacher et al., 2019, p. 383)

- **Compliance** - refers to meeting regulatory requirements. These requirements might be established by a governing board, government decree, rules, or administrative laws, or be mandated by the funding source. Compliance is often determined by a paper trail (these days, often a virtual paper trail), with documentation showing that the program is conforming to the specified requirements (ibid)

- **Quality** - a more abstract concept, is focused more generally on the performance of the program in a manner of excellence or high ability that leads to effective outcomes. Daro (2010) noted both structural aspects of program quality, such as materials, resources, and education and background of staff, as well as more dynamic program features such as the content and nature of supervision sessions, the work environment, and home visitor–parent relationship quality (ibid)

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3. Research approach

Original Research: *This is the most common type of journal manuscript used to publish full reports of data from research. It may be called an Original Article, Research Article, Research, or just Article, depending on the journal. The Original Research format is suitable for many different fields and different types of studies. It includes full Introduction, Methods, Results, and Discussion sections.*

The research approach is based on a review and analysis of research articles, related to the areas of nurturing care, focal points of advocacy and oriented towards policies and programs whose effectiveness has been measured. The review is conducted through a selection of research articles and review articles[7] in two stages and subsequent analysis of the articles.

Review Articles: *Review Articles provide a comprehensive summary of research on a certain topic, and a perspective on the state of the field and where it is heading. They are often written by leaders in a particular discipline after invitation from the editors of a journal. Reviews are often widely read (for example, by researchers looking for a full introduction to a field) and highly cited. Reviews commonly cite approximately 100 primary research articles.*

At the first stage, articles have been selected based on relevance to the key policy areas: access to healthcare services of children aged to 3, pregnant women and mothers; services in support of opportunities for early learning and responsive caregiving; access to services in support of secure and safe environments for children's development; ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line. At the second stage, main criteria for selection of articles are applied:

[7] https://www.springer.com/gp/authors-editors/authorandreviewertutorials/writing-a-journal-manuscript/types-of-journal-articles/10285504

- Articles are directly related to identified evidence-based policy solutions from Part I of the research, whenever possible;
- Articles include description of evidence of effectiveness;
- Articles are published in peer-reviewed journals;
- Research / original articles and review articles;
- Articles are published in English and have not been translated in Bulgarian;
- Full-text access.

The following steps are taken in order to conduct the analysis:

- Initial broad search of literature by keyword (e.g. nurturing care, early learning, HV services, uninsured pregnant women, care and nutrition for new-born babies, etc.) among Web of Science, Scopus, EbscoHost, Science Direct, Research gate, Google scholar; JStor;
- Further narrowing the search focus by applying relevant phrases, fragments of phrases and keywords from each subject area (i.e. focal point of advocacy); Removal of duplicates resulted from searching in multiple databases, containing numerous duplicate citations;
- Setting up inclusion and exclusion criteria (e.g. by population and phenomenon of interest) for each subject area and evaluating the relevance of each study against those criteria;
- Determining the period of publication (1990-2020) to maximally expand the scope of the possible relevant findings;
- Minimizing research bias by applying double check to the set of selected articles in each subject area (by two independent researchers);
- Coding using NVivo 12 software, following an established criteria and coding procedure;
- Further analysis of data.

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The total number of articles, which have been identified when applying the criteria described above, and analysed, in order to achieve the goals, is 69. In table 1, these articles are presented based on the focal point of advocacy they are dedicated to.

Table 1 Selection of research articles

Policy areas	Focal points for advocacy	Number of articles
Access to healthcare services of children aged to 3, pregnant women and mothers	Access to prenatal care of uninsured pregnant women, living in poverty	6
	Healthcare for new-borns through home visits by GPs of paediatricians	9
Services in support of opportunities for early learning and responsive caregiving	Home visiting national programs in support of responsive caregiving during the first 1 000 days of the child's development	8
	Services in support of early learning of children aged to three	10
Access to services in support of secure and safe environments for children's development	Access to health and other public services of undocumented pregnant women and mothers of children up to age three	10
	Community-based services in support of positive parenting in poor environment	10
ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line		16
Total number of articles		69

A coding tree, containing the most important codes, has been developed based on the first reviewed articles. It was used and completed subsequently, while the rest of the articles were

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coded and analysed. The main coding categories are demographics such as country, target group of the program, who conducted the research in the article, main problem, problem solution, research design and methodology, findings and recommendations, etc. Some example coding trees for specific focal points of advocacy are shown in Annex 1.

4. Limitations

There is one important limitation that should be specifically noted: the scope of potentially effective programs and actions in the policy areas might be limited due to the lack of access to full-text articles identified as relevant (by both title and abstract) to the research purposes. Thus, the analysis is concentrated on available full-text sources. To minimize the effect of this limitation we used a broad range of databases and expand the period of publication years.

In addition, information regarding year of research, country of implementation of the program, country of the authors and other aspects, was not always available.

The effort to identify programs in different policy areas led to some programs being included in more than one area. The reason for this is that some programs are integrated and combine different components from different policy areas.

In the area 'Healthcare for new-borns through home visits by GPs or paediatricians', mainly HV programs have been identified, mostly by CHWs (community health workers) and nurses, instead of general practitioners (GPs) or paediatricians, since the two topics are naturally connected with each other.

Also, it is important to mention that the articles cover the period 1990 – 2020, so findings, conclusions and recommendations are also relevant to policies and development, which happened in this period.

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5. Main findings

5.1. Access to healthcare services of children aged to 3, pregnant women and mothers

Fifteen research-based articles have been found relevant and reviewed in this area. The analysis of the findings will be presented separately for the two focal points of advocacy: access to prenatal care of uninsured pregnant women living in poverty and healthcare for new-borns through home visits by GPs and/or paediatricians.

5.1.1. Access to prenatal care of uninsured pregnant women, living in poverty

Overview of the articles

Six research-based articles have been reviewed in this focal point of advocacy. The articles are not related to identified practices in the I part of the research, but rather present programs, related to the key problem and evidence-based solutions. The key demographic characteristics of all of the articles are presented in table 2.

Table 2 Articles in the focal point of advocacy 'Access to prenatal care of uninsured pregnant women, living in poverty'

No	Author/s & year of publication	Publication details and link to abstract or full text (if available)	Country/state of study and/ or program implementation
1	Burger, S. (2010)	A cost consequence analysis of outreach strategies for high risk pregnant women. *Journal of community health nursing*, 27(3),137-145, https://www.jstor.org/stable/20750836?seq=3#metadata_info_tab_contents (full text)	USA
2	Laditka, S. B., Laditka, J. N., & Probst, J. C. (2006)	Racial and ethnic disparities in potentially avoidable delivery complications among pregnant Medicaid beneficiaries in South Carolina. *Maternal and Child Health Journal,* 10(4), 339-350, https://link.springer.com/article/10.1007/s10995-006-0071-5 (abstract)	USA/ South Carolina
3	Long, S. H., & Marquis, M. S. (1998)	The effects of Florida's Medicaid eligibility expansion for pregnant women. *American Journal of Public Health*, *88*(3), 371-376, https://pubmed.ncbi.nlm.nih.gov/9518966/(abstract)	USA/ Florida

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4	Piper, J. M., Mitchel Jr, E. F., & Ray, W. (1994)	Presumptive eligibility for pregnant Medicaid enrolees: its effects on prenatal care and perinatal outcome. *American journal of public health*, *84*(10), 1626-1630, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1615092/ (abstract)	USA/ Tennessee
5	Rittenhouse, D. R., Braveman, P., & Marchi, K. (2003)	Improvements in prenatal insurance coverage and utilization of care in California: an unsung public health victory. *Maternal and child health journal*, 7(2), 75-86, https://link.springer.com/article/10.1023/A:1023812009298 (abstract)	USA/ California
6	Rowland, D., Salganicoff, A., & Keenan, P. S. (1999)	The key to the door: Medicaid's role in improving health care for women and children. Annual Review of Public Health, 20(1), 403-426, https://pubmed.ncbi.nlm.nih.gov/10352864/ (abstract)	USA

Medicaid *was enacted in 1965 as part of the Social Security Act to provide health coverage to families with dependent children living below the 'federal poverty line' (FPL). Medicaid is the single largest source of health coverage in the United States.*

The main demographic characteristics of the articles include **country, in which the program is implemented, target group(s), year of the study, who conducted the study**. The problem of access to prenatal care of low-income uninsured pregnant women is broadly discussed in the scholarly literature. To illustrate the significance of the problem and effective solutions proposed to overcome

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disparities in access to care six articles were found mostly relevant and were reviewed. All these articles are directly related to the U.S. program Medicaid[8] and one focuses on three outreach strategies (i.e. outreach workers, liaison workers, and case managers) used by a community-based organization with the well-established Healthy Start program[9] to enrol uninsured, low-income pregnant women in prenatal health care services.

> ***Healthy Start*** *begins in 1991 with a goal to reduce infant mortality by 50% in 5 years. The Healthy Start Program provides health insurance to low-income, uninsured pregnant women in order to improve access to early, comprehensive, and continuous prenatal care to improve the health of new-borns and their mothers in the United States.*

Depending on the study purposes, the main **target group** of the most of studies are vulnerable, low-income pregnant women. As obvious from the table 1, four articles devoted to Medicaid cover several states, namely, **California, Tennessee, South Carolina, and Florida**, and one summarised Medicaid program for the **U.S.** The Healthy Start connected article (i.e. Burger, 2010) presents results from a study carried out in **North-eastern United States**.

The articles are published between **1994 - 2010,** most of them by academic researchers. The authors of one article are with RAND, Washington, DC, while the authors of another one represented Henry J. Kaiser Family Foundation, Washington DC.

Main identified problems and purposes of the articles

The main problems, targeted in most of the articles, relate to access to prenatal care and disparities in healthcare for vulnerable low-income and minority populations affected by the programs' implementation.

In the years preceding Medicaid's enactment in the U.S., the financing and provision of health care to the poor has been 'a meager combination of charity care and reliance on public hospitals and clinics, coupled with limited assistance from public welfare and maternal and child health

[8] https://www.medicaid.gov/about-us/index.html
[9] http://www.nationalhealthystart.org/healthy_start_initiative

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funding. Medicaid was intended to reform the financing of care to the poor by providing matching federal funds to states for the care of the medically indigent' (Rowland et al., 1999, p. 404). As obvious from the program explanation above, it has evolved over the years to expand its scope and effectiveness. The analysed articles give clear evidence about the impact of the introduction of certain strategies in this direction, as well as of the program as a whole. Thus, the study of Rittenhouse et al. (2003) focuses on trends in prenatal insurance coverage and utilization of care for more than 10 million women giving birth in California over a 20-year period under the Medi-Cal (Medicaid for California) and aims to assess the effects of the state's efforts to increase access to prenatal care through the program.

Long & Marquis (1998) focus on the eligibility expansion of Medicaid to improve access to prenatal care for low-income women and thereby to improve birth outcomes and infant health in Florida. The objective is 'to study whether pregnant women newly entitled to Medicaid coverage received more or earlier prenatal care and whether their birth outcomes were improved' (p. 371).

Piper, Mitchel, and Ray (1994) study the effect of the introduction of the so-called presumptive eligibility by investigating outcome rates for pregnant Medicaid enrolees 6 months before and 6 months after presumptive eligibility have been in effect. The study population comprises of white and black women who have delivered a single live infant with a recorded birthweight of 500 to 6000 g or a stillborn infant (ibid, p. 1657).

Laditka, Laditka, & Probst (2006) concentrate on racial and ethnic disparities in prenatal care among Medicaid beneficiaries in South Carolina by using the so-called Potentially Avoidable Maternity Complications (PAMCs) indicator. Thus, the authors investigate 'differences in outcomes associated with the accessibility and qualities of prenatal care among Black, Hispanic, and White women' (ibid, p. 340).

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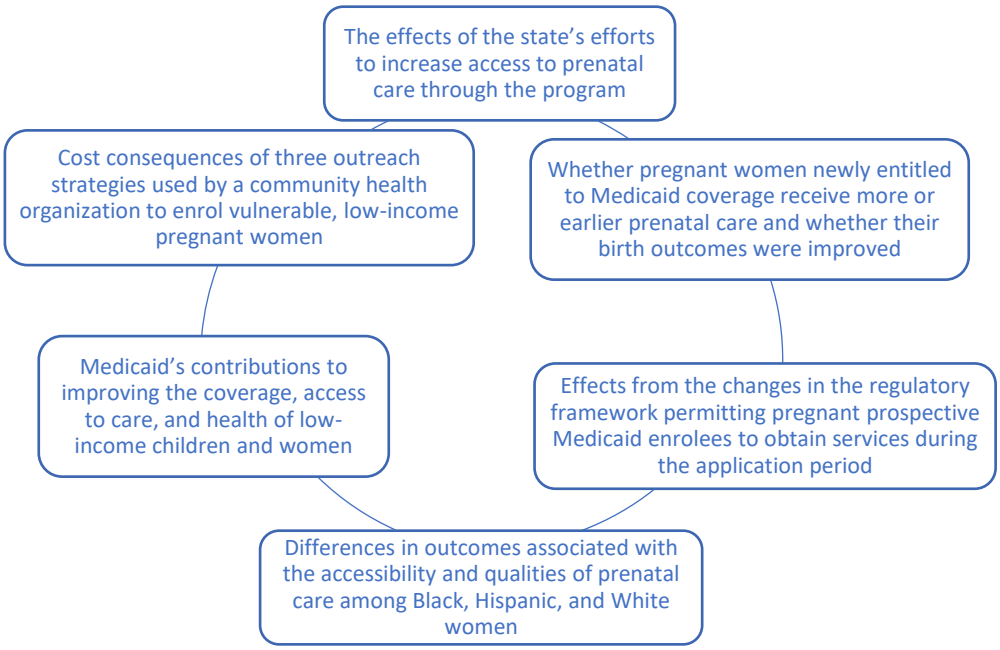
The article of Rowland, Salganicoff, and Keenan (1999) assesses Medicaid's contributions over three decades to improving the coverage, access to care, and health of low-income children and women.

In addition to this area of analysis, the article of Burger (2010) focuses on the effectiveness of the Healthy Start program, which is a specific federal program implemented in the U.S. to minimize disparities in the access to clinically appropriate care, particularly among minority and low-income populations. The research study of Burger (2010) specifically examines the cost consequences of three outreach strategies (outreach workers, liaison workers, and case managers) used by a community health organization in a mid-sized city in North-eastern United States to enrol vulnerable, low-income pregnant women into comprehensive perinatal health care services.

All these articles follow the effects from the enrolment in the program in various directions: access, effectiveness, outcomes, cost consequences, regulatory framework development, associated with enrolment in the program (Figure 1).

Figure 1 Purposes of the articles



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Rowland et al. (1999, p. 408) state that services for pregnant women are limited to pregnancy-related care and, unless the women meet other Medicaid criteria for assistance, benefits are terminated 60 days postpartum.

Furthermore, it is largely substantiated by research evidence that racial and ethnic disparities exist in prenatal care for Black women in comparison to non-Hispanic White women regarding pregnancy complications (Laditka et al., 2006).

According to Burger (2010), a large body of evidence suggests that there are longstanding barriers to enrolling and retaining eligible children and families into public health insurance. Those barriers 'related to vulnerable and low-income status include culture, language, inaccessible locations for applying, complex application procedures, and inability to pay for health care services' (ibid, p. 138).

Medicaid

Created in 1965, Medicaid is a joint federal and state program that provides health coverage to over 72.5 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States. **Income eligibility** for Medicaid is based on Modified Adjusted Gross Income (MAGI) for most children, pregnant women, parents, and adults. **Non-financial eligibility criteria** are based on residency of the state in which you are receiving Medicaid, citizenship of the United States or permanent residency. Some eligibility groups are limited by age, pregnancy, or parenting status. **Mandatory eligibility groups** are low-income families, **qualified pregnant women and children,** poverty level related: pregnant women, infants, children aged 1-5, newborns, etc.).

The problems, reviewed in the articles, are recognised at a national level and the barriers are related to vulnerable and low-income status of the target groups of the programs.

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Problem solutions

Problems with access to prenatal care of vulnerable, low-income, pregnant women are recognized at national level, resulting in efforts to increase prenatal insurance coverage by certain measures implemented at federal and states' level.

Problem solutions include 'increasing the income eligibility level, streamlining the application process, allowing continuous eligibility during pregnancy, and instituting presumptive eligibility (immediate temporary coverage for pregnant women who believe they are eligible)' (Rittenhouse et al., 2003, p. 75).

Healthy Start USA

Healthy Start is a federal program **aimed at** improving maternal and child health outcomes by increasing access to and use of health services. It provides health insurance to **low-income, uninsured pregnant women** in order to improve access to early, comprehensive, and continuous prenatal care to improve the health of newborns and their mothers. Healthy Start is **state funded** in the USA. It was **launched** in 1991 by the US Public Health Service. The program is **currently in implementation** across the states.

Healthy Start programs **provide:** referral and ongoing health care coordination, prenatal, postpartum, and childcare; supportive/enabling services including: outreach, case management, HV, father involvement, child development education and parenting support, linkage to housing assistance, adult education, and job training programs; and health education and support related to breastfeeding, safe sleep, perinatal mood disorders, substance use, and intimate partner violence.

Medicaid[10] was initiated as a health-financing program for the welfare population, originally focused mainly on single mothers and their children eligible for welfare (Rowland et al., 1999, p. 404). It is defined as the nation's major public financing program for health insurance coverage and long-term care services for the poor and since its establishment 'has evolved as the

[10] https://www.medicaid.gov/

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predominant insurer of low-income children and many of their parents, regardless of their welfare status' in the U.S. (ibid, p. 403).

To improve the quality of and access to health care for vulnerable, low-income, pregnant women the Healthy Start program[11] works with individual communities through outreach, health education, case management, and utilization of care (Burger, 2010). The outreach strategies used to assist the target groups in the enrolment process for comprehensive perinatal health care services are outreach workers, liaison workers, and case managers.

Conceptual framework

Some of the studies are based on an **ecological framework** that allows for the problems to be examined and understood within the broader context and complex interplay of biological, psychological, socio-economic, cultural, and political factors. The study of Burger (2010), in particular, is based on the ecological framework for policy studies of Milio (1988), which models the relationship between public policy, health organizations, and population health outcomes. It focuses on social climate, organizational strategies, and community health outcomes as key elements of the aforementioned framework (ibid, p. 138). Social climate includes environmental conditions, such as population demographics, economic indicators, political priorities, issues and views of the mass media and public opinion, and organizational hierarchies, which together can enable or constrain the movement of any policy related to access to care for vulnerable populations. Organizational strategies refer to the fiscal, administrative, programmatic, and informational strategies used by this community health organization related to outreach and enrolment of low-income, uninsured pregnant women into comprehensive perinatal health care services. Community health outcomes comprised of individual-level indicators, such as low birth weight (under 2,500 grams), very low birth weight (under 1,500 grams) and early prenatal care (prenatal care started in the first trimester) aggregated to the community level (ibid, p. 138).

[11] http://www.nationalhealthystart.org/healthy_start_initiative
https://link.springer.com/article/10.1007/s10995-017-2404-y

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Rittenhouse et al. (2003) provide **an ecological study** of the efforts of California to increase access to prenatal care following Medicaid maternity expansions. The study builds on the California's birth certificate data considered to be 'particularly useful because information on prenatal care insurance coverage has been collected since 1989, when the number of prenatal care visits and mother's educational attainment also were added. These data elements allow for examination of insurance coverage along with two aspects of prenatal care utilization (timeliness of initiation and number of visits), as well as education, an important socioeconomic factor' (ibid, p. 76). Based on the assumption that at least one prenatal visit during the first trimester is of vital importance, which has been recognized by the U.S. Public Health Service as a national health priority, the study focused on first-trimester initiation of prenatal care and examined the adequacy of the number of prenatal care visits. Birth certification data variables under study are prenatal insurance coverage, prenatal care utilization, and maternal characteristics (ibid, p. 77).

Piper et al. (1994) uses data from Tennessee birth, foetal death, and death certificates and Tennessee Medicaid files to examine the effects of presumptive eligibility on pregnancy outcomes as part of a series of investigations of Tennessee Medicaid expansions for pregnant women. The authors expect their findings to predict subsequent changes in other states and the country as a whole.

Laditka et al. (2006) use an approach that investigates maternal health through PAMCs as an indicator of the accessibility and effectiveness of health care during pregnancy. This indicator functions through the expectation that risks may be reduced through healthy behaviours that may be promoted by prenatal care. Unlike previous studies that used PAMC indicator to examine ethic and racial disparities in delivery outcomes but did not account for socio-demographic factors, Laditka et al. (2006) fill this gap by using 'information from a state-wide data base in South Carolina, which included detailed individual-level sociodemographic characteristics such as marital and disability status, income, and education, for mothers insured by Medicaid' (ibid, p. 340). Thus, they use PAMC as dependent variable and factors that have been associated with

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medical risk, health seeking behaviours, and access to services., as independent variables (ibid, p. 341-342).

Study design and methodology. Findings

The **study design and methodology** are presented in a different way in the different articles, related to the purpose and conceptual framework. The study design of the studies in the articles varies: a retrospective ecological analysis (Rittenhouse et al., 2003); a comparative study (Long & Marquis, 1998; Piper et al., 1994); a cross-sectional analysis (Laditka et al., 2006) and a review (Rowland et al., 1999).

Most of the studies are conducted based on secondary data analysis, since there is available data in the target country – USA. The study design is mostly comparative, longitudinal, and cost consequence.

The study design of Burger (2010) includes a **retrospective cost consequence analysis**. The methodology is based on a **quantitative method** – a survey instrument to use as an interview guide during data collection. Data 'to describe outreach and enrolment strategies were collected from 10 key informants using the Enrolment Interventions: Time Estimates of Personnel Questionnaire' (ibid, p. 139). Healthy Start network database served as a database for determining the number of individuals enrolled in Healthy Start program and the maternal-child outcomes. In addition, evidence was collected from other public sources (ibid, p. 140). The study of Burger (2010) focused on cost-effectiveness of outreach strategies of an agency that served a highly disadvantaged population in a city with economic indicators well below both the county and state averages and where the number of individuals living in poverty is more than twice that of the county and three times the state averages (p. 141). As **findings**, data analysis showed that 'enrolment in the study agency results in much better outcomes in terms of birth weight than the city population as a whole. This reduction in the number of low-birth-weight babies and related neonatal complications leads to both short- and long-term cost savings. As the majority of participants are low-income Hispanic or African American women, enrolment in this program

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helps to eliminate the health disparities experienced by disadvantaged populations' (ibid, p. 143). Another finding is that only 46% of the participants received prenatal care in the first trimester, which indicates barriers to access to care and that 'proactive outreach and recruitment strategies such as those employed by the study agency are necessary to overcome these barriers to enrolment and utilization of services' (ibid, p. 143). The need of a database 'to track the unduplicated citywide count of pregnant and interconceptual women receiving Healthy Start services and assess the psycho-social needs of each enrolled client' is identified (ibid, p. 143). It was estimated that out of 897 individuals recruited and enrolled in comprehensive health care services, 190 were enrolled by outreach workers, 553 by liaison workers, and 145 by case managers. The cost per enrolee by strategy were: outreach workers: $429 per enrolee; liaison workers: $98 per enrolee; and case managers: $187 per enrolee (ibid, p. 141-142). Based on the findings, the liaison worker was the most cost-effective enrolment strategy (ibid, p. 143).

The **ecological study** of Rittenhouse et al. (2003, p. 75) involves a methodology based on secondary data collection from retrospective univariate and bivariate analyses of prenatal care coverage and utilization of data from 10,192,165 California birth certificates, 1980–99; descriptive analysis of California poverty and unemployment data from the U.S. Census Bureau Current Population Survey; and review of public health and social policy literature. **The finding** of the study show 'a sharp decline in the early 1990s in the proportion of women in California with no insurance coverage throughout pregnancy' (p. 81-82). Changes in the organisation and financing of health care delivery during the study period such as the introduction of managed care have been considered as a factor in this direction (ibid, p. 83). The observed improvements in prenatal care insurance coverage and utilization of care, especially for disadvantaged groups of women, in California in the 1990s have been attributed to the multifaceted public health effort including policies that substantially expanded Medi-Cal eligibility by nearly doubling the income eligibility limit, extending coverage to undocumented women, and eliminating the assets tests (ibid, p.84).

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Laditka et al. (2006) have conducted a cross-sectional analysis of PAMC prevalence in Black, Hispanic, and White mothers in the year 2000. Secondary data analysis is conducted, regarding 26,866 Medicaid-insured deliveries, obtained from the South Carolina Office of Research and Statistics, and Area Resource File. PAMC risks of Blacks, Hispanics, and Whites are estimated through analysing PAMC rates, Chi-square, t-tests, multilevel logistic regression. Risks were estimated for ages 10–17, and 18 + (ibid, p. 339). Laditka et al. (2006) examined racial and ethnic disparities in PAMC separately for mothers aged 10–17, and aged 18 and over, and **found** that among younger mothers, Blacks had higher PAMC risks than Whites (p. 344), while the adjusted odds of a PAMC for Black mothers aged 18 and older did not differ from those of Whites (ibid, p. 345). **Another finding** is that 'the higher prevalence of risk factors associated with pregnancy complications for Blacks was much more pronounced among mothers ages 18 and over, than in those ages 10–17', which is found consistent with the theory of cumulative life course disadvantage (ibid, p. 345). Generally, 'for adult Medicaid beneficiaries in South Carolina, the results suggest that poverty, lack of social support, the presence of diabetes, and living in a rural county are the underlying factors for some racial disparities in avoidable pregnancy morbidity' (ibid, p. 348).

To study effects of Florida's Medicaid eligibility expansion for pregnant women, Long and Marquis (1998) have conducted **secondary data analysis**, by comparing '4 groups of pregnant women: women enrolled in Medicaid under the eligibility expansion (group 1); those enrolled in Medicaid because of their participation in Aid to Families with Dependant Chidren (AFDC) (group 2); uninsured women and those with non-private third party coverage other than Medicaid who resided in low-income areas (group 3); and those with private insurance who resided in low-income areas (group 4)'(Long and Marquis, 1998, p. 372). The final analysis sample includes 56 101 women in the baseline period and 78 421 women in 1991. Data is analysed through regression analysis. Concurrent and longitudinal comparisons are performed with matched birth and death certificates, hospital discharge data, Medicaid eligibility records, and records from county health departments for women giving birth from July 1988 to June 1989 (n = 56 101) or in calendar year 1991 (n = 78 421).

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The study of Medicaid eligibility expansion in Florida **found** that regarding the pre-post expansion comparison 'access to prenatal care for the target population - low-income women without private insurance - improved significantly after the Medicaid eligibility expansion' (Long & Marquis, 1998, p. 373). It is also observed that birth outcomes have improved over the study period for low-income women without private insurance and statistically significant reductions have been found in the number of low-birthweight babies (61.8 vs 67.9 per 1000) and in the number of infant deaths (5.9 vs 7.3 per 1000) (ibid, p. 373). **These findings** are explained with the precise research methods used in this study and the specifics of Florida experience, where most of the additional prenatal care financed by Medicaid have been accommodated in the county health departments; 'the better birth outcomes among those in the public delivery system occurred despite later initiation of care and fewer prenatal clinical visits for this population', which 'suggests the importance of the care coordination and expanded nonclinical services that the public system offers' (ibid, p. 375). However, the authors report that there is still a significant gap between Medicaid-eligible women and low-income privately insured women in use of prenatal care and in birth outcomes (ibid, p. 375).

Piper et al. (1994) have carried out **a comparative study** by conducting secondary data analysis to assess the effects of presumptive eligibility for pregnant women enrolled in Medicaid. Data is obtained from Tennessee birth, foetal death, and death certificates and Tennessee Medicaid files. **Findings** of the study, based on the comparison between two groups of pregnant women, enrolled in Medicaid, before and after enrolment, shows that 'women in the 'after' group were 40% more likely to enrol and 30% more likely to obtain prenatal care in the first trimester (p. 1630). It demonstrates that presumptive eligibility increased the proportion of women who enrolled in Medicaid during the first trimester and reduced the proportions of those who failed to begin prenatal care in the first trimester, those who obtained inadequate care, and those who delayed obtaining care until the third trimester or failed to get any care at all (p. 1630). However, no difference was observed in adverse outcomes of pregnancy between the two groups (ibid, p. 1630).

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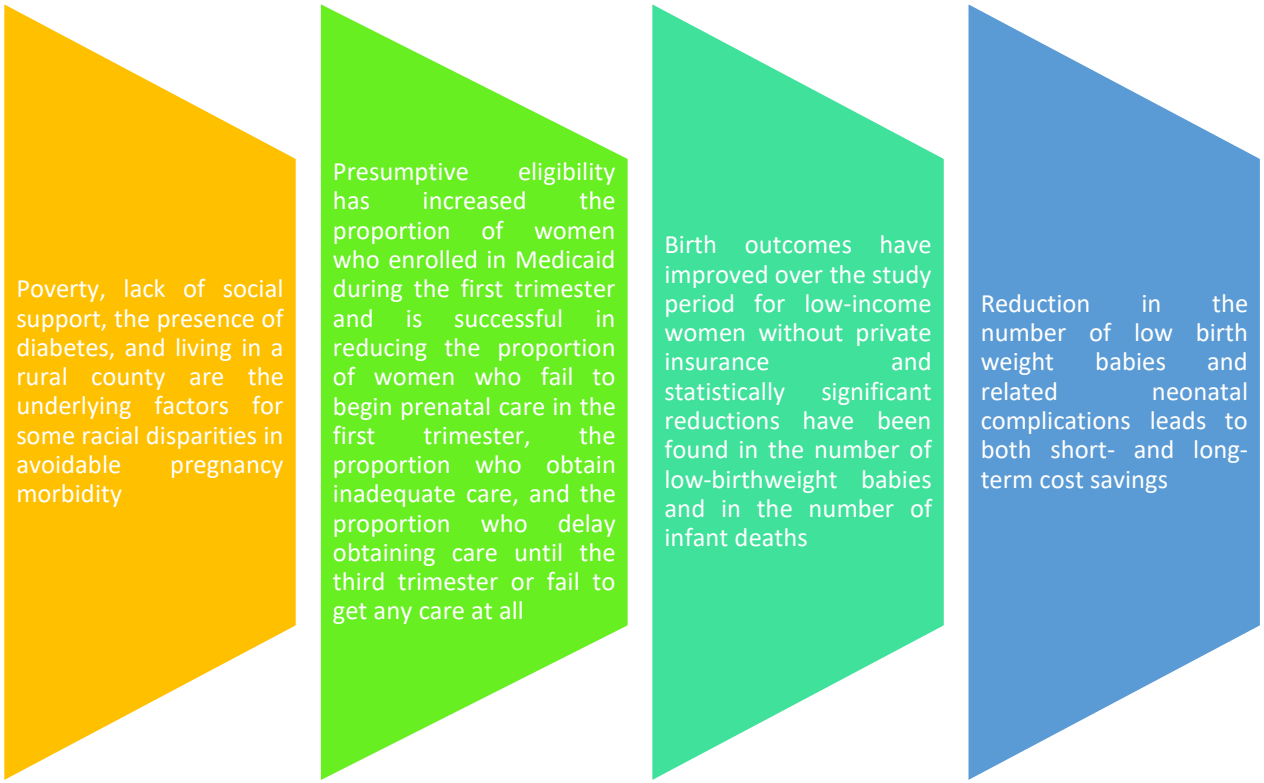
Conclusions of the review article show that 'Nationally, the total share of women who receive late or no prenatal care fell from 6.1% in 1990 to a low of 4.4% in 1995'; women with Medicaid have better access to early and adequate prenatal care than those the uninsured but 'still lag behind their privately insured counterparts in terms of access to prenatal care' (p. 416). Over the three decades Medicaid has shown 'that it is an important lever to help open the door to better health care, and ultimately to improved health for America's poor women and children, by substantially expanding coverage of the low-income population and helping to reduce differentials in access to care between the poor and the privately insured. Gaps in coverage and limitations in access persist, but overall, the program has resulted in better coverage, access, and health care for millions of poor children and their parents' (Rowland et al. 1999, p. 422).

Figure 2 Findings regarding access to prenatal care of uninsured pregnant women



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Recommendations in the articles

The recommendations in the analysed studies vary in terms of scope. Burger (2010) recommends use of **proactive outreach and recruitment strategies** to overcome barriers to enrolment and utilization of services for prenatal care and reduce disparities of low-income, vulnerable populations; the **creation of a database for joint decision-making**.

Rittenhouse et al. (2003, p. 85) recommend **continuing investments in Medicaid and similar programs.**

According to Piper et al. (1994, p. 1630), when barriers to prenatal care, including bureaucratic ones, are removed, low-income women will seek care earlier and more frequently; **universal health care coverage** for pregnant women will improve the receipt of prenatal care.

Laditka et al. (2006, p. 348) recommends using **integrated approaches** to prenatal services for low-income women, such as psycho-social, health education, and nutrition programs, which would be **particularly helpful for adolescent mothers**. PAMC risks can be reduced through prenatal care, such as infection screening and treatment, and healthy behaviours it promotes. **Policies to reduce PAMCs** in Medicaid should address needs of young Blacks and Hispanics; enhance diabetes treatment for adult women; and address rural access barriers for all women. Prenatal care for Medicaid beneficiaries should particularly stress treatment of diabetes for women of all races. More studies in more states with varied circumstances should provide a more comprehensive picture of the effects of Medicaid expansion efforts (Long & Marquis, 1998; 349).

In general, given examples of policies and programs intended to provide access to health care and prenatal care for uninsured, low-income, pregnant women, in particular, demonstrate that the latter is a matter of national priority. It should be noted that currently all pregnant women who have income below 138 percent of the poverty line are among the so called 'mandatory' populations covered by Medicaid. Evidence shows that initiatives such as Healthy Start could improve access to health care of vulnerable, low-income, pregnant women. It is also a matter

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of national priority. Depending on the context, some outreach strategies (liaison workers) proved to be more cost-effective than others.

5.1.2. Healthcare for new-borns through home visits by GPs or paediatricians

Overview of the articles

Nine research-based articles have been reviewed in this focal point of advocacy. All of these articles present different models for home visits, they are not related to the I part of the research direct, but they upgrade information about the topic. The key demographic characteristics of all of the articles are presented in table 3.

Table 3 Articles in the focal point of advocacy 'Healthcare for new-borns through home visits by GPs or pediatricians'

No	Author/s & year of publication	Publication details and link to abstract or full text (if available)	Country/state of study and/ or program implementation
1	Lori, J. R., Perosky, J., Munro-Kramer, M. L., Veliz, P., Musonda, G., Kaunda, J., ... & Scott, N. (2019)	Maternity waiting homes as part of a comprehensive approach to maternal and newborn care: a cross-sectional survey. *BMC pregnancy and childbirth*, *19*(1), 228, https://www.researchgate.net/publication/334243223_Maternity_waiting_homes_as_part_of_a_comprehensive_approach_to_maternal_and_newborn_care_a_cross-sectional_survey (full text)	Zambia
2	Maldonado, L. Y., Songok, J. J., Snelgrove, J. W., Ochieng, C. B., Chelagat, S., Ikemeri, J. E., ... & Christoffersen-Deb, A. (2020)	Promoting positive maternal, newborn, and child health behaviors through a group-based health education and microfinance program: a prospective matched cohort study in western Kenya. *BMC Pregnancy and Childbirth*, *20*, 1-14, https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-020-02978-w (full text)	Kenya
3	Miró, R. Á., Canut, M. L., Aloy, J. F., Ruiz, M. E., Gili, L. A., Rodríguez, J. B., & Estrany, X. C. (2014)	Influence of in-home nursing care on the weight of the early discharged preterm newborn. *Anales de Pediatría (English Edition)*, *81*(6), 352-359, https://analesdepediatria.org/en-influence-in-home-nursing-care-on-articulo-S2341287914001082 (full text)	Spain
4	Pineda, R.,	The Baby Bridge program: A sustainable program that can improve	USA

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	Heiny, E., Nellis, P., Smith, J., McGrath, J. M., Collins, M., & Barker, A. (2020)	therapy service delivery for preterm infants following NICU discharge. *Plos one*, *15*(5), e0233411, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0233411 (full text)	
5	Roisne´, J., Delattre, M., Rousseau, S., Bourlet, A., Charkaluk, M.-L. (2018)	Newborn follow-up after discharge from the maternity unit: Compliance with national guidelines, *Archives de Pe´diatrie, 25*, 95–99, https://www.sciencedirect.com/science/article/abs/pii/S0929693X17305225 (abstract)	France
6	Silva, R. M. M. D., Zilly, A., Nonose, E. R. D. S., Fonseca, L. M. M., & Mello, D. F. D. (2020)	Care opportunities for premature infants: home visits and telephone support. *Revista Latino-Americana de Enfermagem*, *28,* https://www.researchgate.net/publication/342615780_Care_opportunities_for_premature_infants_home_visits_and_telephone_support (full text)	Brazil
7	Sitrin, D., Guenther, T., Waiswa, P., Namutamba, S., Namazzi, G., Sharma, S., ... & Chimbalanga, E. (2015)	Improving newborn care practices through home visits: lessons from Malawi, Nepal, Bangladesh, and Uganda. *Global health action*, *8*(1), 23963, https://www.researchgate.net/publication/274571472_Improving_newborn_care_practices_through_home_visits_Lessons_from_Malawi_Nepal_Bangladesh_and_Uganda (full text)	Malawi, Nepal, Bangladesh, and Uganda
8	Tesfau, Y. B., Kahsay, A. B., Gebrehiwot, T. G., Medhanyie, A. A., & Godefay, H. (2020)	Postnatal home visits by health extension workers in rural areas of Ethiopia: a cross-sectional study design. *BMC Pregnancy and Childbirth*, *20*, 1-9, https://www.researchgate.net/publication/341492255_Postnatal_home_visits_by_health_extension_workers_in_rural_areas_of_Ethiopia_a_cross-sectional_study_design (full text)	Ethiopia
9	Wilson, A. N., Spotswood, N., Hayman, G. S., Vogel, J. P., Narasia, J., Elijah, A., ... & Homer, C. S. E. (2020)	Improving the quality of maternal and newborn care in the Pacific region: A scoping review. *The Lancet Regional Health-Western Pacific*, *3*, 100028, https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(20)30028-6/fulltext	The Pacific region

The main demographic characteristics of the articles include **country (countries), in which the program is implemented, target groups, year of the study, who conducted the study**. Countries where the programs and studies were implemented are as follows: USA; France; Spain; Zambia; Kenya; Ethiopia; Malawi, Nepal, Bangladesh, and Uganda; Brazil; and the Pacific region.

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> ***In 2009, World Health Organization (WHO) and United Nations Children's Fund (UNICEF) issued a joint statement recommending postnatal home visits (PNHVs) for delivery of PNC. Following the 2009 Joint Statement, many countries adopted policies to deliver postnatal home visits (Tesfau, 2020, p. 2)***

Years of research are mentioned for 7 of the studies. Most of them are very recent, implemented between **2013 and 2019 year**. One is for 2007-2009.

Generally, studies subject to the above articles were conducted by **research teams from universities and hospitals**. Most of the articles are research articles and one is a review article.

Both mothers and new-borns constitute **the main target groups** of the studies. Depending on the scope of the studies, they include all women with live births; preterm infants; pregnant women; mothers with premature infants; mother-infant pairs. The specific target group of each individual study is mentioned in the sections concerning purposes and study design &methodologies below.

Main identified problems and purposes of the articles

Problems tackled in the articles relate to access, provision and quality of maternal and new-born care and are significant. Evidence shows that many countries, primarily **low and middle-income countries (LMICs)**, face significant challenges regarding **postnatal care (PNC) for mothers and new-borns**. It is estimated that, globally, 60% of **maternal deaths occur during the postnatal period** (Lori et al., 2019), while nearly all deaths in new-borns (99%) occur in low or middle-income countries (Sitrin et al., 2015).

The ratio of **maternal and neonatal mortality** is huge for many countries, including Ethiopia, Kenya, Zambia, Uganda, the Pacific region, etc. In Ethiopia, maternal and neonatal mortality remains the highest among the world, at 412/100,000 and 30/1000, respectively (Tesfau et al., 2020, p. 2). Similar evidence is reported for rural Kenya (Maldonado et al., 2020) and Zambia (Lori at al., 2019). **PNC utilization coverage** is low due to barriers such as 'unavailability, inaccessibility, poor quality of health services, socio-cultural beliefs, awareness on danger signs of postnatal

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period, and distance' (Tesfau et al., 2020, p. 2). Maldonado et al. (2020, p. 2) stated that women of lower socioeconomic status often encounter **greater barriers to accessing high quality care**.

Underutilization of life-saving health services were attributed to multiple factors, including living in poor, remote communities (Lori at al., 2019). Data show that 'improvements in the quality of facility care, including preconception, antenatal, intrapartum and PNC, for mothers and babies could prevent approximately 113,0 0 0 maternal deaths, 531,0 0 0 stillbirths and 1.3 million neonatal deaths each year' (Wilson et al., 2020, p.2). Low antenatal care (ANC) attendance, high unmet family planning needs, high rates of preterm birth, sexual reproductive tract infections, teenage pregnancy and gender-based violence are all challenges that lead to **increased maternal and new-born morbidity and mortality** across the Pacific region (ibid, p, 2).

In addition to the above, evidence show that **premature births are a risk factor for infant morbidity and mortality** and add up to approximately 15 million annually worldwide (Silva et al., 2020, p. 2). They have a high risk of developmental delays, including motor, cognitive, and language difficulties, as well as behavioural and learning problems (Pineda et al., 2020, p. 2). The authors cited the Centre for Disease Control (CDC), which documented that preterm birth is the leading cause of long-term disability, as well as a significant source of emotional and economic burden for families (ibid, p. 2). After hospitalization, the health complications in terms of neurodevelopment require access to continuity of care provided by health professionals at home (Silva et al., 2020, p. 2). It is noted that 'evidence shows **the importance of approaches in family environments through Home Visits (HVs) and/or telephone support**, increasing health, survival, and development' (ibid, p. 2). For infants with already identified neurodevelopmental impairment who are at risk of long-term disabilities referrals are made to early intervention and therapy programs, which are most beneficial (Pineda et al., 2020, p. 2). Evidence shows however that **therapy is often difficult to access** and preterm infants discharged from neonatal intensive care units (NICU) may wait between four to five months before they receive services (ibid, p. 2).

The **barriers** that contribute to the delay, include low income, low maternal education, single-family households, minority status, and high social risk (ibid, p. 2-3). Programs, such as the Baby

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Bridge, improved access to early therapy services and proved to be an effective and feasible to implement strategy (ibid, p. 3). However, the cost effectiveness of such programs may be an **issue** that can cause their cessation.

Developed countries explore follow-up care strategies to improve healthcare for mothers and new-borns. For example, the evidence show that in-home nursing (IHN) care program 'improves the relationship and satisfaction of the parents, as it helps normalise the situation at home, promotes breastfeeding, and leads to increased weight gain, improved development and a decreased risk of infection in the new-born. It also allows for a higher degree of customisation in health education and a reorganisation of healthcare resources that is more satisfactory to the user' (Mirò et al., 2014, p. 353). The medical follow-up care of term new-borns after maternity unit discharge is a well-established practice in many countries in Europe (Roisne´, 2017, p. 96). The evidence show that the hospital stays after delivery have shorten over the years in Europe and particularly France. Implementation of the national guidelines, however, face some **challenges** and there is **no certainty they are effectively applied** (ibid, p. 95).

Problems are widely recognized by both international organizations, such as WHO, UNICEF, the World Bank, and national governments. Many practices are introduced to reduce the maternal and infant morbidity and mortality and promote healthy behaviours. A number of studies demonstrate that home visits by trained CHWs can change new-born care practices.

As the **main problems** seem to be common while the **purposes** of the articles are quite specific, they will be presented separately article by article (following the logic of developing to developed countries):

The research article of Tesfau et al. (2020) aims to determine the coverage and contents of postnatal home visits and associated factors by **health extension workers** (HEWs) in Northern Ethiopia. The study was conducted August to September 2018 among **705 mothers** who gave live birth in the year preceding the data collection (i.e. 2017). Authors identified a paucity on the

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evidence about the coverage of the early postnatal home visits and the contents of the care provided by HEWs during those visits in rural Tigray, Northern Ethiopia.

Similarly, the problem with high maternal and new-born mortality rates and promotion of health behaviours in rural Western Kenya was addressed by a specific program called **Chamas for Change (Chamas)** (Maldonado et al. 2020). Chamas represents a cultural practice in East Africa that has been existing for ages. It means 'groups with purpose', which are highly gendered and provide support and resource pooling (ibid, p. 2-3). The research article of Maldonado et al (2020) evaluates the association between participation in Chamas and facility-based delivery and explored the effect of this participation on promoting other positive maternal, new-born and child health behaviours in Western Kenya. The final target sample size of Maldonado et al' study comprised of **267 participants**.

The importance of ANC and PNC to reduce the poor maternal and new-born outcomes for women living in disadvantaged, remote communities, is widely recognized (Lori et al., 2019). The paucity of evidence on the relationship between **maternity waiting homes** and **utilization of care** as well as on the level of engagement of women in the services has been identified in the research article of Lori at al. (2019). The study aims to assess the associations among maternity waiting homes use and antenatal and postnatal attendance, family planning, and immunization rates of new-borns for mothers living in seven rural districts in **Zambia** (ibid, p. 2). The study was conducted in 2013-2014 and included **women who delivered a child** in the past 13 months.

The **review** article of Wilson et al. (2020) aims to identify all published studies of interventions which sought to improve the quality of maternal and new-born care in Pacific low-and middle-income countries. The main problem is that those nations face challenges in delivering quality maternal and new-born care, including high maternal and new-born morbidity and mortality in first 24 hours, due to many reasons. The authors identified a particular lack of evidence regarding the actions taken by LMICs in the Pacific region to achieve quality maternal and new-born care. Thus, the aim of the scoping review was 'to collate, analyse and categorise health system quality

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improvement efforts that aimed to improve the quality of maternal and new-born care in LMICs in the Pacific region, and summarise major findings from these studies' (ibid, p. 2).

The research article of Sitrin et al. (2015) aims to evaluate **population level changes in selected new-born care practices** over time in pilot areas in four countries (Malawi, Nepal, Bangladesh, and Uganda) with different health system contexts and to learn whether women who received home visits from CHWs were more likely to report use of these practices. The study was conducted in 2019. The target group consisted of **women with a live birth in the previous 12 months** in those four countries.

The original article of Silva et al. (2020) aims to analyse opportunities for guidance to promote the care of premature infant in home visits and support through telephone. The evidence showed that investments to structure the teams of primary care services and to organize health actions in households are limited and that the use of telephone support as a means to improve health care access and efficiency is not well explored in **Brazil**. The target group comprised of **18 mothers of premature infants** discharged from hospital. The study was conducted between July 2017 and April 2018 in Foz do Iguaçu-PR-Brazil.

The research article of Pineda et al. (2020) is based on a project that aims to determine revenues and costs over time to assess the sustainability of the **Baby Bridge program in the U.S.** The study was carried out over 2 year's period (January 2016 to January 2018) with **95 high-risk infants** who were being discharged from the NICU at St. Louis Children's Hospital. Infants were enrolled in the Baby Bridge program and received weekly therapy services in their homes until other community-based (early intervention) services commenced (ibid, p. 3). As the research data has shown improvements in access to early therapy services with the Baby Bridge program, the authors aimed to 'calculate the costs of the Baby Bridge program to compare it against revenues in order to assess sustainability for possible scale-up across sites' (ibid, p. 3). Description of the program and its' costs and revenues are shown in the section of findings.

The original article of Miró et al. (2014) presents a study conducted in 2007-2009 in Barcelona, Spain, and focuses on **IHN care**, 'that is the care and follow-up of the new-born at his or her home

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rather than in the pre-discharge incubator at the hospital' as part of the new trends in neonatal care in developed countries' (ibid, p. 353). The study aims to show that IHN care of the preterm new-born after early discharge fosters weight gain in the home, and is also safe, as it does not result in increased morbidity. The target group consisted of healthy preterm neonates from the Hospital Clinic de Barcelona.

Finally, the research paper of Roisne et al. (2018) aims to describe **care practices during the 1st month of life for term infants** discharged from three maternity units in northern France. In 2014 the French health authorities issued guidelines recommended post discharge follow-up care with a home visit from a midwife and a ''new medical examination to be performed between the 6th and 10th day of life by a paediatrician or a GP with new-born care training' (ibid., p. 1). The target group consisted of **108 mother-infant pairs** discharged in March and April 2015 from three maternity units in northern France that participate in the Baby Friendly Hospital Initiative.

As obvious from the above description, **the main problems** emphasized in the articles related to maternal and new-born health and care (eight articles), including maternal and infant deaths and care for preterm new-borns. One article is devoted to the Baby Bridge program sustainability, namely, the article of Pineda et al. (2020).

Problem solutions

Problem solutions derived from the studies could be summarized in three main directions: (Figure 3)

- Home visits provided by health extension visitors/ CHWs/ volunteers/ nurses/ GPs and/or paediatricians;
- Programs to improve maternal and new-born care, such as a group-based health education and microfinance program/ the Baby Bridge program for occupational therapy/ telephone support in addition to home visits for preterm infants;
- Maternity waiting homes as a means to provide a continuum of care in remote areas.

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All of them are directed to **vulnerable populations** in countries where they are implemented and are **supported** by the respective governments. More specifically, in 2003, **Ethiopia** has introduced a **health extension program** to decrease the high percentage of maternal and infant mortality and to facilitate and increase the utilization of ANC and institutional delivery. HEWs from the communities were trained to provide basic maternal and new-born health care during the antenatal, delivery and postnatal period through home visits (Thesfau et al., 2020, p. 2). The postnatal home visits generally include services provided at home for the mother and the new-born. For mothers, those services cover assessing general condition, checking vital signs and danger signs, and for the new-borns, home visiting (HV) includes a general body examination, checking general danger signs, checking the cord for any bleeding and infection, and assessing breast feeding (ibid, p. 2). This program **Chamas for Change**[12] (Maldonado et al., 2020) was created by the Academic Model Providing Access to Healthcare (AMPATH), **in partnership with the Government of Kenya** in 2012. The program is facilitated by **community health volunteers (CHVs)** and offers pregnant women **free health and microfinance education** in a supportive group setting during the antenatal and postpartum period. Chamas represents a cultural practice in East Africa that has been existing for ages. It means 'groups with purpose', which are highly gendered and provide

Chamas for Change

Chama for Change is designed as an integrated solution to the widespread poverty, violence and neglect that undermine adult capabilities and child development. This project seeks to extend the scope and duration of Chama cha Mama Toto as a population-wide strategy to promote good health, provide skills-enrichment to adults and children, and protect against the toxic stresses of poverty, violence and neglect through parenting education provided by trained CHVs.

Facilitated by government CHVs, *chamas* are a low-cost, self-sustaining and self-managed solution that integrates health, social and financial literacy education with a savings/loans program. Upon joining, women pledge to participate in bi-weekly meetings for one year and uphold the goals of the *chama*: support each other, save and become entrepreneurs, and commit to self-selected health and child development goals.

[12] https://www.savingbrainsinnovation.net/projects/0729-03/

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support and resource pooling (ibid, p. 2-3). Thus, Chamas introduces **an integrated model** that aims to improve health outcomes and empower women to live financially secured lives by combining best practices from women's health and microfinance programs (ibid, p. 3).

Maternity waiting homes or mother's shelters that serves to are structures built near healthcare facilities that serve to minimize the distance and 'can contribute to a larger health system strengthening effort to connect women to the health facility and to ANC and PNC services for both mothers and new-borns', thus ensuring **the continuum of care** (Lori at al., 2019, p. 2).

Save the Children's Saving Newborn Lives

Since 2000, SNL has worked to raise awareness, conduct research and support country- and global-level efforts to institutionalize equitable and highly effective coverage of high-impact newborn services and practices at national scale.

SNL works with governments and partners to keep newborn health on global and national agendas, and catalyzes action by developing, applying and documenting evidence-based newborn care services and practices. In addition, SNL promotes the increased availability of and access to routine and emergency new-born care services and supplies, improved quality of new-born care services and dissemination of evidence about and creation of increased demand for new-born care. SNL works with global partners and in four priority countries, collaborating with country governments, development partners, civil society and other strategic partners to catalyse action to improve health outcomes for newborns.

Practices under study of Sitrin et al. (2015) were interventions for new-borns at community level, including promotion and provision of **thermal care, early and exclusive breastfeeding, and hygienic cord care** (ibid, p. 2). Those interventions were provided through **home visits by trained CHWs**. Save the Children's Saving Newborn Lives (SNL)[13] program supported **ministries of health** and partners in Malawi, Nepal, Bangladesh, and Uganda to develop and test new-born programs (Sitrin et al., 2015).

The Baby Bridge program was supported as **a pilot program** to see if sustainability could be achieved, through the **Washington University School of Medicine's Program in Occupational Therapy**. The program focuses on promotion of timely, consistent, and high-quality early therapy

[13] https://www.savethechildren.org/us/what-we-do/health/newborn-health

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services for high-risk infants following NICU discharge. Key features of the Baby Bridge program include: '1) having the therapist establish rapport with the family while in the NICU, 2) scheduling the first home visit within one week of discharge and continuing weekly visits until other services commence, 3) conducting comprehensive assessments to inform targeted interventions by a skilled, single provider, and 4) using a comprehensive therapeutic approach while collaborating with the NICU medical team and community therapy providers' (Pineda et al., 2020, p. 1).

Baby Bridge Program

The program is **directed to** promotion of timely, consistent and high-quality early therapy services for high-risk infants following NICU discharge. It is implemented in an urban site with a billing infrastructure and a **specific payer mix with a high proportion of infants/families with Medicaid**. All high-risk infants in the NICU who were referred for therapy (occupational therapy, physical therapy or speech-language pathology) at NICU discharge are **eligible for the program**. **The program includes** home visits by a therapist with a comprehensive therapeutic approach incl. education, advocacy, support, fostering an appropriate environment for skill acquisition, providing resources and targeted interventions for infants and families.

Conceptual framework

Conceptual frameworks are not specifically mentioned in the articles. It could be noted, however, that most of the studies and particularly those in African and Asian countries are community-based studies. Each of the studies steps on previous research and determines dependable and independent variables on the basis of the specific purpose and context.

Study design and methodology. Findings

The study design and methodology used differ depending on the purpose, scope, and others.

Most of the study design and methodological approaches explored primarily quantitative methods by administering questionnaires either directly or online. One article presents a qualitative study that uses the philosophical hermeneutics as a method for data analysis. The review article was based on the scoping review framework.

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The study of Maldonado et al. (2020) explored a **prospective, matched-cohort study design.** It included **comparison of outcomes** between a cohort of Chamas participants recruited during their first ANC visits at public health facilities and controls receiving the standard of care identified through health facility registers, matched for age, parity, and prenatal care location. Both cohorts were prospectively followed for one year and recorded outcome data 12 months following enrolment for all participants (ibid, p. 3). Data were collected at two time points using paper-based, structured, data collection forms. Relevant statistical methods were used to process and analyse data. **Findings** from the study suggest that the HV programs implemented in various cultural contexts lead to improvement of PNC for mothers and new-borns (Maldonado et al., 2020). The study revealed that compared to controls, a significantly higher proportion of Chamas participants delivered in a health facility (84.4% vs. 50.4%, $p < 0.05$), attended at least 4 ANC visits (64.0% vs. 37.4%, $p < 0.05$), received a CHV home visit within 48 h postpartum (75.8% vs. 38.3%, $p < 0.05$), and exclusively breastfed to 6 months postpartum (82.0% vs. 47.0%, $p < 0.05$). In addition, women in Chamas experienced a lower proportion of stillbirths (0.9% vs. 5.2%), miscarriages (5.2% vs. 7.8%), infant deaths (2.8% vs. 3.4%), and maternal deaths (0.9% vs. 1.7%) as compared to controls.0.001) (ibid. p. 7). Finally, participation in a group-based health education and microfinance program during the antenatal and postpartum period was associated with higher odds of facility-based delivery compared to the standard of care. Program participation also promoted the practice of other positive MNCH behaviours (ibid, p. 12).

Lori et al. (2019, p. 1)) used a **cross-sectional household survey** to collect data from women who delivered a child in the past 13 months from catchment areas associated with 40 healthcare facilities in seven rural Saving Mothers Giving Life districts in Zambia. Multi-stage random sampling procedures were employed with a final sample of n = 2381. Logistic regression models with adjusted odds ratios and 95% confidence intervals were used to analyse the data. The study **found** a positive association between maternity waiting home use and number of ANC visits (four or more visits), attending all PNC visits, and increased contraceptive use of any kind to avoid pregnancy. Thus, the authors stressed on the potential influence of a comprehensive package of services for women living in rural, remote areas (ibid, p, 4).

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The design of Sitrin et al. (2015) study uses data from **cross-sectional surveys of women** with live births at baseline and end line. The Pearson chi-squared test to assess changes over time, and generalised linear models were used to assess the relationship between the main independent variable - home visit from a CHW during pregnancy (0, 1-2, 3+) - and use of selected practices while controlling for ANC, place of delivery, and maternal age and education (p. 1). **Findings** suggested statistically significant improvements in all practices (i.e. breastfeeding, cord care, thermal care), except applying nothing to the cord in Malawi and early initiation of breastfeeding in Bangladesh (Sitrin et al., 2015, p. 6). Women who were visited by a CHW three or more times during pregnancy in Malawi, Nepal, and Bangladesh, and women who delivered in a facility in Malawi, Nepal, and Uganda were more likely to report use of selected practices (ibid, p. 7-10). The general conclusion is that home visits by CHWs during pregnancy can play a role in improving practices in different cultural settings; the impact of home visit programmes on new-born care practices may be greatest in areas with high rates of home delivery; facility delivery is the most important predictor for ensuring new-born care practices (ibid, p. 10).

Tesfau et al. (2020, p. 3) conducted a **community-based cross-sectional survey** in Nothern Ethiopia among mothers who gave live birth in the past year before the survey/data collection. Data were collected with an interviewer-administered structured questionnaire containing items regarding socio-demographic, status towards model household, community based participations like pregnant women forum, women development group (WDG), and community health insurance membership, availability of HEW cell phone numbers at home, time taken to visit the household, ANC attendance (both facility and home), place of delivery, birth notification, attendants at birth, postnatal visits and contents of PNC provided (ibid, p. 3). Twenty two-days trained interviewers visited each eligible woman at her home. For the study purposes, the postnatal home visit is defined as at least one home visit by HEW within 3 days after childbirth; the coverage of postnatal home visits was defined as the percentage of women and/or new-borns that were visited at home within 3 days after delivery; and the contents of the postnatal home visits were measured by mothers/caretakers words (mention – not mention) (ibid, p. 3). Relevant methods for data processing were used. The study of Tesfau at al. (2020, p. 6) **found** a

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low coverage: 102 (14.5%) mothers and new-borns received postnatal home visits (PNHVs) within 3 days after delivery; 170 (24.1%) mothers and their new-borns received PNHVs by the HEWs throughout the postnatal period. In addition, the HEWs did not address the full contents of PNHV both for the mother and new-born (ibid, p. 6). Some of those findings were consistent with the results from others similar studies in Africa and Asia and the others were not (ibid, p. 7). Finally, it is concluded that the coverage of postnatal home visits by HEWs remains low in rural districts of Northern Ethiopia and that the factors associated with PNHVs include a home visit by HEWs during pregnancy, participation in the pregnant women forum, birth notification and, being a member of community health insurance (ibid, p. 8).

Miró et al. (2014) explored a **comparative case---control (1:1) study** of 65 cases and 65 controls (matched by weight, age and sex), all of them preterm new-borns born in hospital and weighing less than 2100 g at discharge (p. 353-355). A number of statistical procedures was applied to analyse the results. Regarding the influence of IHN care on the weight of the early discharged preterm new-born it is **found** that 'IHN results in increased weight gain in the new-born that is at home rather than remaining hospitalised, and can be considered safe, as it is not associated with increased neonatal morbidity' (Miró et al., 2014, p. 358).

Roisne et al. (2018) study 'was **observational, prospective, and multicentred**. Follow-up practices (medical visit between the 6th and 10th day, home visits from a midwife) and demographic, social, and medical data were recorded during the stay in the maternity unit, and through a phone interview 1 month later, in singleton term-born infants' (p. 95). The study of mother–infant pairs discharged from three maternity wards participating in the **Baby Friendly Hospital Initiative**[14], **found** that a follow-up visit was effectively performed for only 20 of term new-borns discharged before the 6th day of life. Furthermore, 'a great majority of new-borns had home visits by midwives, but 25% were not seen by a midwife or by a physician between the 6th and 10th day of life' (Roisne´ et al., 2018, p. 97). Two-thirds of the new-borns in the study population had a visit from a midwife between the 6th and 10th day of life, but in France the

[14] https://sites.unicef.org/nutrition/index_24806.html

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midwife is skilled to manage a very limited number of pathological conditions and cannot replace the physician for planning subsequent infant follow-up (Roisne´ et al., 2018, p. 98-99).

The qualitative study of Silva et al. (2020, p. 5) **found** that home visits and telephone support in providing care for premature infants favoured the perception of health needs and daily doubts of basic care and provided resolution of problems. The collaborative practice of home visit and telephone support increases care opportunities and thus may prevent further complications in situation of prematurity (ibid, p. 6).

Finally, the study of the cost-effectiveness of the Baby Bridge programming **compared the total costs and revenues of the program over a span of 2 years.** The total cost of the therapist, mileage and travel expenses, and equipment were calculated, and claims were then compared to cost over time to assess sustainability of Baby Bridge programming (Pineda et al., 2020, p.3). The results from the cost effectiveness analysis of the Baby Bridge program to improve early therapy delivery in order to impact outcomes of high risk infants being discharged from the NICU proved that **it is cost effective and achieved sustainability within 16 months of implementation**. The **conclusion** is that 'In 2016, the first year of programming, the Baby Bridge program experienced a loss of $26,460, with revenue to the program totalling $11,138 and expenses totalling $37,598. In 2017, the Baby Bridge program experienced a net positive income of $2,969, with revenues to the program totalling $53,989 and expenses totalling $51,020. By Spring 2017, 16 months after initiating Baby Bridge programming, program revenue began to exceed cost. It is projected that cumulative revenue would have exceeded cumulative costs by January 2019, 3 years following implementation. Net annual program income, once scaled up to capacity, would be approximately $16,308'.

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Figure 3 Findings regarding healthcare for new-borns through home visits

Recommendations in the articles

On the basis of the findings, several **recommendations** were made and could be summarized in as follows:

- In addition to pregnancy visits, efforts should be made for mothers to enrol in the community-based health insurance[15]. Existing health systems should consider interventions that improve pregnancy and birth notification strategies, and more efforts should be made in improving community-based participation and linkages with CHWs (Tesfau et al., 2020).

[15] **Community-based health insurance** (CBHI) schemes are usually voluntary and characterized by **community** members pooling funds to offset the cost of **healthcare**. According to WHO, however, 'the traditional CBHI model – relying only on voluntary, small-scale schemes with little or no subsidization of poor and vulnerable groups – can play only a limited role in helping countries move towards universal health coverage (UHC)' (www.who.int)

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- Not only to promoting positive behaviours but also to bolster the quality of services provided to those who seek them (Maldonado et al., 2020)
- Developing a comprehensive package of services for maternal and new-born care has the potential to improve the availability, accessibility, and acceptability of care for mothers and new-borns in low-resource settings (Lori et al., 2019)
- Multiple interactions are needed to change behaviour, so programmes need to investigate the most appropriate and efficient ways to reach families and promote new-born care practices (Sitrin et al., 2015)

Policies and programs subject to the articles are only examples that illustrate the role of the investments in community-based strategies to improve access to healthcare for mothers and new-borns in disadvantaged areas. On the basis of the search and analysis of articles in this particular area of advocacy, it could be summarized that various practices exist and are successfully implemented depending on the cultural context and national specifics. They include involvement of paraprofessionals or trained people from the community, not necessarily professionals such as nurses or pediatricians. It must be noted that, in Bulgaria, practices and professions such as patronage nurses and health mediators working with disadvantaged families and communities can be considered appropriate and helpful regarding maternal and new-born care.

5.2. Services in support of opportunities for early learning and responsive caregiving

5.2.1. Home visiting national programs in support of responsive caregiving during the first 1 000 days of the child's development

Overview of the articles

Eight research-based articles were reviewed in this focal point of advocacy. One of them is related directly to the first report in this research (part I) –the Home Start program, the rest upgrade

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information from the I part with many more HV programs (mainly in the USA, as well as internationally acclaimed and implemented programs). The key demographic characteristics about them are presented in table 4.

Table 4 Articles in the focal point of advocacy 'Home visiting national programs in support of responsive caregiving during the first 1 000 days of the child's development'

№	Author/s & year of publication	Publication details and link to abstract or full text (if available)	Country/state of study and/ or program implementation
1	Asscher et al. (2008)	Asscher, J. J., Hermanns, J. M., & Deković, M. (2008). Effectiveness of the Home-Start parenting support program: Behavioral outcomes for parents and children. Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health, 29(2), 95-113 Retrieved from: https://www.home-start.nl/documenten/Onderzoek%20publicaties%20artikelen/2008%20Effectiveness%20of%20the%20Home-Start%20program.pdf	The Netherlands
2	Lanier et al. (2015)	Lanier, P., Maguire-Jack, K., & Welch, H. (2015). A nationally representative study of early childhood home visiting service	USA
3	Lucas et al. (2018)	Lucas, J. E., Richter, L. M., & Daelmans, B. (2018). Care for Child Development: an intervention in support of responsive caregiving and early child development. Child: Care, health and development, 44(1), 41-49. Retrieved from: https://bit.ly/3p1oRnj	International
4	Cho et al. (2018)	Cho, J., Bae, D., Terris, D. D., Glisson, R. E., & Brown, A. (2018). Community contextual effects on at-risk mothers' engagement in Georgia's Maternal, Infant, and Early Childhood Home Visiting programme. Child & Family Social Work, 23(4), 590-598. Retrieved from (abstract only): https://onlinelibrary.wiley.com/doi/abs/10.1111/cfs.12448	USA
5	Dodge et al. (2019)	Dodge, K. A., Goodman, W. B., Bai, Y., O'Donnell, K., & Murphy, R. A. (2019). Effect of a Community Agency–Administered Nurse Home Visitation Program on Program Use and Maternal and Infant Health Outcomes: A Randomized Clinical Trial. JAMA network open, 2(11), e1914522-e1914522. Retrieved from: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2753795	USA
6	Korfmacher et al. (2019)	Korfmacher, J., Frese, M., & Gowani, S. (2019). Examining program quality in early childhood home visiting: From infrastructure to relationships. Infant mental health journal, 40(3), 380-394. Retrieved from: https://onlinelibrary.wiley.com/doi/10.1002/imhj.21773 (abstract only)	USA

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7	Kilburn & Cannon (2017)	Kilburn, M. R., & Cannon, J. S. (2017). Home visiting and use of infant health care: a randomized clinical trial. Pediatrics, 139(1). Retrieved from: https://pubmed.ncbi.nlm.nih.gov/27980028/ (abstract only)	USA
8	McBride & Peterson (1997)	McBride, S. L., & Peterson, C. (1997). Home-Based Early Intervention with Families of Children with Disabilities: Who is Doing What? Topics in Early Childhood Special Education, 17(2), 209-233. Retrieved from: https://journals.sagepub.com/doi/10.1177/027112149701700206 (abstract only)	USA

The data from the analysis shows that most studies are focused on universal HV programs. This is, notably, the focal point of advocacy, in which most practices are concentrated and developed across a lot of countries. It is important to point out that the ECD and the need for responsive caregiving are recognised as priorities in and outside the EU and in USA and HV is common in different form (usually universal or targeted toward vulnerable groups) and scope in most countries. One of the articles is related to practices from the first part of the study: a Dutch evaluation of the effectiveness of the Home Start program in the country.

The main demographic characteristics of the articles include **country (countries), in which the program is implemented, target group(s), year of the study, who conducted the research**. In the focal point of advocacy *Home visiting national programs in support of responsive caregiving during the first 1 000 days of the child's development*, there are a lot of countries, in which the studies from the selected articles, are based. This is due to the fact that some of the articles have an international scope. Other articles present studies, based in USA and one is based in the Netherlands, as mentioned. The target groups are families with children at an early age, beneficiaries of a home-visiting program, mothers and children in general, uninsured low-income pregnant women, young children, as well as children with disabilities and their families. Most studies are conducted after the year 2000, only one is from 1993. The rest are implemented between 2008 and 2019. This means that most studies and, therefore, implemented HV programs, are relatively new. It could be pointed out that such programs have been developed in the USA earlier than in some European countries, according to the reviewed articles. When it comes to who conducted the research, this is mostly universities, independent consultants, and research institutes, meaning that most often these are public entities, but one of the models is supported by both public and private funding.

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Main identified problems and purposes of the articles

The main **problems**, targeted in most of the articles, relate to the areas of healthcare and parenting, such as punitive parenting behaviour, health disparities experienced by underserved and disadvantaged populations, elevated risk of poor physical or developmental outcomes, elevated risk of failing to achieve human potential, inadequate nutrition and frequent illness contributing to stunted growth, family-level risk factors, parental stress and risk of mental health problems, childhood psychological and behavioural problems, child abuse and neglect, lack of proper PNC, etc.

The first article of Asscher et al. (2008), is dedicated to the effectiveness of the home-start parenting **s**upport program and behavioural outcomes for parents and children. According to his view, 'some parents feel unable to cope with the demands placed upon them and parental well-being, often defined in terms of self-efficacy with regard to parenting and/or levels of depressive moods, may diminish. Low parental well-being can have a disruptive effect on the family system and parenting style. This can lead to less supportive and more punitive parenting behaviour that negatively influences child development. Diminished maternal well-being is associated with a broad range of negative child outcomes such as internalizing behavioural problems as well as aggressive and disruptive behaviour. The degree, to which mothers experience parenting as being difficult and unsatisfactory, is one of the most important contextual factors for the well-being of children' (ibid, p. 97).

The article of Lucas et al. (2018, p. 41, p. 42) focuses on similar problems, but it looks at them from an even broader point of view **to document the effectiveness of an HV program**– '43% of children younger than 5 years of age are at an elevated risk of failing to achieve their human potential'…'inadequate nutrition and frequent illness contribute to stunted growth, and growing up in an unstable environment further limits cognitive and social potential'.

Kilburn & Cannon (2017, p.2) have researched HV and use of infant health care. The stated problems, as in previous articles, are related to the issues that HV tackles, but are more specific. The authors state that 'number of hospitalizations, overnight stays in the hospital, emergency

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department (ED) visits, and visits to the family doctor' are all indicators of unsolved issues, related to HV.

McBride & Peterson (1997) conducted a research on a home-based early intervention with families of children with disabilities and focused on the question who is doing what. According to them, not enough access to comprehensive community services, the need for emotional support to family members, coordination of services, as well as the need for supporting and facilitating parent-child interactions, or for providing direct therapy to the child, are all central issues.

According to another article, **centralized on the community contextual effects on at-risk mothers' engagement** in Georgia's maternal, infant, and early childhood HV program, family-level risk factors, parental stress and risk of mental health problems, childhood psychological and behavioural problems, child abuse and neglect are crucial issues and need the focus of attention in policy and practice (Cho et al., 2018, p. 590).

Lanier et al. (2015) have conducted a **nationally representative study** of early childhood HV service use in the United States. According to their research, the problem is in access to HV services by disadvantaged populations, since 'important predictors of HV use include infant/ child need factors (health risk, adverse experiences), predisposing factors (family size), and enabling factors (insurance type). This study provides the first estimates of national and state HV service use. Although findings indicate HV services are targeted to children at elevated risk for poor physical or developmental outcomes, our estimates show the vast majority of at-risk children did not receive HV services, including more than 80 % of low-income children, 76 % of preterm infants, and 57 % of very low birth weight infants' (ibid, p. 2147).

In Korfmacher et al.'s view (2019, p. 382) who have examined program quality in early childhood HV with a focus on both infrastructure and relationships, 'home visiting has in many ways promised more than it has delivered. Results are often inconsistent and modest, and although longitudinal and cost–benefit analyses point toward the ultimate long-term benefit of at least some home-visiting services, there remains an underlying concern that too often home visiting is not of high-enough quality to make a meaningful difference in the lives of vulnerable children

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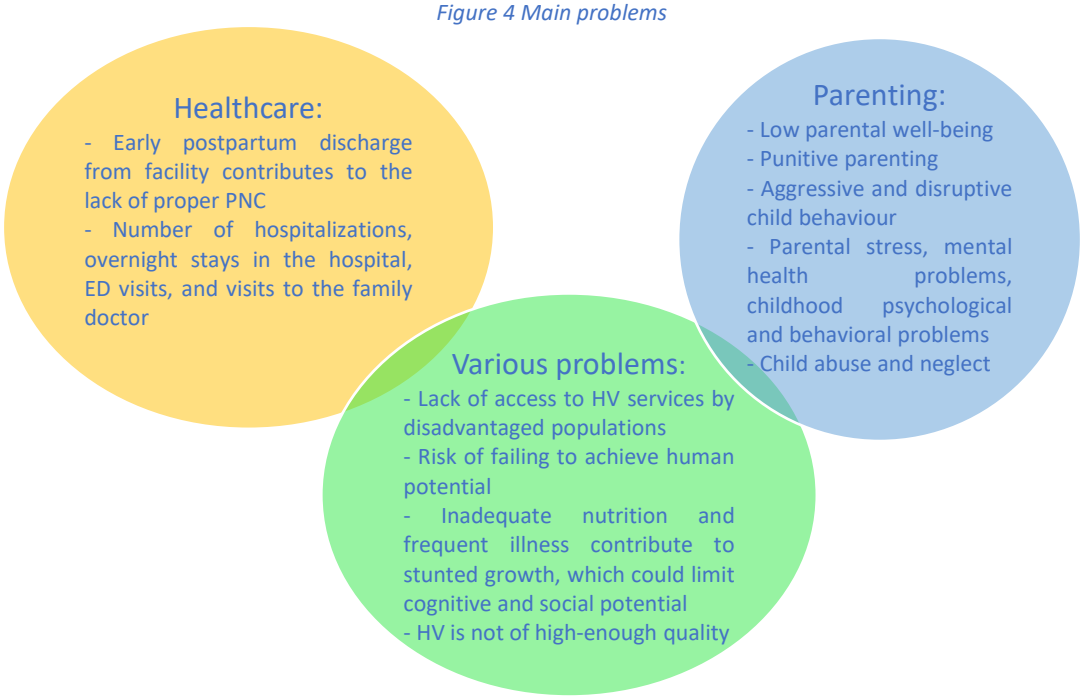
and their families. Because of the high expectations our current policy landscape has placed on home visiting, both in the United States and globally, if programs cannot deliver services well and move the needle in improving child health and well-being, future funding and program development may be put at risk.' This central problem is different from those stated above in the other articles, reviewed so far, since it focuses on the effectiveness of HV, instead of the problems it targets itself.

According to Dodge et al. (2019, p. 1) who studied the effect of a community agency–administered nurse home visitation program on program use and maternal and infant health outcomes, 'postnatal home visitation to support parenting and infant healthy development is becoming increasingly common based on university efficacy studies, but **effectiveness when disseminated by communities is not clear'**.

Figure 4 Main problems



In the following text is presented the evidence base regarding **significance of the problems**. It could be noted that the body of evidence on the topic of HV is bigger than in most of the other focal points of advocacy, since the practice is more common among different countries. However,

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according to the evidence base in most of the articles, research on HV is either scarce in general or certain aspects have not been studied sufficiently.

In some articles, the accumulated body of evidence points both to positive and negative/none effects of HV interventions (Asscher et al., 2008, p. 97-98) - 'reported some positive, though mainly mixed, findings with regard to the effectiveness of early intervention programs on parents. Some studies have found effects on certain areas aimed at by the intervention, but never on all. For example, Seitz, Rosenbaum, and Apfel (1985) found improvement on parental initiative concerning involvement with their child's schooling, but not for self-reported parenting practices; and some effects in regard to school attendance, but none on the child's IQ. Connolly, Sharry, and Fitzpatrick (2001) found a decrease in behavioural problems of children, but no changes with regard to parental wellbeing.'

According to the article of McBride & Peterson (1997, p. 212), 'The majority of research on home-based service delivery has been done with programs providing services to families to prevent preterm delivery and/or low birthweight and those that promote child development in low-income families or families at risk for child maltreatment (Halpern, 1984, 1986; Olds & Kitzman, 1993). Halpern (1984) summarized the following findings regarding home-based services with this population: (a) Effects are not consistently found in the same developmental domain across studies; (b) positive effects, when found, are modest in magnitude; and (c) there is little evidence of long-term effects. Failure to find strong effects for HV has been attributed to measurement and design issues such as insufficient control for family or child characteristics and limited description about the type and intensity of intervention (Halpern, 1984)'.

Some authors, such as Lanier et al. (2015), point out that HV has been used over a century in order to improve and promote young children and pregnant women's health. It includes a diverse array of services, which can range from one-time visits of public health workers or teachers to multi-year or multi-week home visits from nurses. As it can be seen, the two focal points of advocacy of healthcare for new-borns through home visits by GPS or paediatricians, and HV

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national programs in the first 1000 days of the child's development naturally blend together, since they are connected in the policy and understanding in different countries.

Positive effects of HV are cited in most of the articles, but there are also some exceptions (Korfmacher et al., 2019), as it was mentioned in the problem section. 'Early childhood home visiting is a service-delivery mechanism of both great promise and some peril. We say promise because recent reports have highlighted the successes that have been shown in the literature (e.g., Association of State and Tribal Home Visiting Initiatives, 2018), and the Home Visiting Evidence of Effectiveness website has documented the 20 evidence-based models of home visiting that have been shown to promote child development and well-being. There has been a dramatic investment in funding for these programs in the past decade across multiple levels. We say peril as well because home visiting has in many ways promised more than it has delivered' (ibid, p. 382).

According to the body of evidence in some articles, (Dodge et al., 2019), HV services are effective in developing countries, but more studies are necessary to determine what is their level of effectiveness and cost-effectiveness. 'Home visitation programs promoting healthy development in early childhood have proliferated based on promising empirical evidence. The federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, implemented across the different states in USA, allocates $400 million annually to programs with positive impact demonstrated through randomized clinical trials. Simultaneously, the field is challenged by failures to replicate findings when university-developed programs are implemented by community agencies, known as the scale-up penalty. The need for studies of implementation and impact of intervention in community settings is one of the highest priorities in medicine' (ibid, p. 2)

The main problems, targeted in most of the articles, relate to the areas of healthcare and parenting, such as punitive parenting behaviour, health disparities experienced by underserved and disadvantaged populations, elevated risk for poor physical or developmental outcomes, elevated risk of failing to achieve human potential, inadequate nutrition and frequent illness

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contributing to stunted growth, family-level risk factors, parental stress and risk of mental health problems, childhood psychological and behavioural problems, child abuse and neglect, lack of proper PNC, etc. In addition, according to the evidence base in most of the articles, research on HV is either scarce in general or certain aspects have not been studied sufficiently.

The purposes of the studies are mostly related to studying the effectiveness of HV programs. The first purpose is examining whether HV improves well-being of mothers or leads to changes in their behaviours (Asscher et al., 2008). This article, as mentioned above, is dedicated to **studying the effectiveness** of an HV program.

Lucas et al. (2018) present worldwide interventions of international organisations such as Care for Child Development (CCD), developed by the WHO and UNICEF, based on the science of child development, to improve sensitive and responsive caregiving and promote the psychosocial development of young children, since WHO and UNICEF identified sites where CCD has been implemented and sustained and the sites were surveyed. The main purpose, as pointed out above, is **to document the effectiveness** of HV programs for ECD.

Researchers also **tested whether a universal HV model employing a nurse–parent educator team as home visitors reduces health care use in the first year of life** (Kilburn & Cannon, 2017).

A purpose that should be noted is examining the extent to which home visits were individualized in terms of available family resources and level of child's caretaking demands in order to take a first step in describing the content addressed and the processes employed during home visits conducted by early childhood special educators and **to explore the extent to which home visits are individualized for various children and families (with a focus on children with disabilities)** (McBride & Peterson, 1997).

The study of Cho et al. (2018) examined **family and community factors** related to HV **programme engagement** among mothers who participated in family support programmes funded through Georgia's MIECHV program.

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Another identified purpose is assessing the extent to which HV use is associated with selected predisposing factors (risk factors), enabling factors, and need, focusing on research questions such as what the prevalence of HV is use in the United States among children 0–3 years, what variation exists in HV use across states and which individual and state-level variables predict HV use (Lanier et al., 2015). The overall purpose is to determine **the scope of usage of the program and its availability.**

Another purpose is documenting the experience of creating a state-wide monitoring system **to assess home-visiting program quality** and compliance to identified standards and integrating multiple sources of information across different domains of functioning (Korfmacher et al., 2019).

Dodge et al. (2019) **tested the implementation and impact** of the Family Connects (FC) program when administered by a community agency with a focus on the effect of a nurse home visitation program for families with new-borns implemented in a community setting on program penetration and fidelity and family outcomes.

The purposes of the studies are mostly related to studying the effectiveness of HV programs. Other purposes include researching the cost consequence and evaluating the cost effectiveness of HV programs, as well as assessing the program quality, implementation and impact, its scope and availability. Two of the articles focus on specific aspects like the extent to which home visits are individualized for various children and families and whether HV use reduces health care use in the first year of life.

Problem solutions

The **problem solutions** in the articles include mostly universal HV models, targeted HV programs, early intervention programs, outreach strategies and counselling programs. In addition, there is a focus on targeted HV programs, meaning that they are oriented towards vulnerable target groups, such as socio-economically disadvantaged families with young children, children with disabilities and others.

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The early intervention program that is the problem solution in one of the articles, is Home Start (since the program is international, it is important to point out that here the focus is on Home Start in the Netherlands[16]) (Asscher et al., 2008), as it was already mentioned above. 'Early intervention programs are designed to support healthy developmental progress in families with young children. The long-term goal of these interventions is the prevention of family dysfunction and behavioural problems of the child in later developmental periods. The category of early intervention programs on which the current study focused was that of parenting support programs. Parenting support programs aim to improve family functioning by means of supporting parents. The present study focuses on the Home-Start Program, one of the various programs designed to support parents with young children. The program works with volunteers

Home Start

Parenting support programs like Home Start **aim to** improve family functioning by means of supporting parents and are designed to support healthy developmental progress in families with young children. The long-term goal of these interventions is the prevention of family dysfunction and behavioural problems of the child in later developmental periods. **Funding** for the Home Start program in the Netherlands comes from government sources and from the two largest national lotteries, private foundations and other private sources. The **launch** of Home-Start Netherlands was in 1996 and it is **currently in implementation**. The **criteria for enrolment** in Home Start Netherlands are: to have children 0 to 14/17 years old, depending on the municipality; to apply for Home Start in the municipality where you live. Home Start Netherlands ensures **access to low-income pregnant women** in the same way as for the rest of the target group. According to data, 70% of beneficiaries of the program come themselves via a referrer, meaning district nurses, general practitioners, general social workers, counselors from the pre-school or community school, workers in day-care centers or playgroups, etc. 30% come themselves via family, acquaintances or the media. **The program works with** volunteers who visit mothers for half a day once a week. Provision of social support by the volunteers is geared to increase maternal well-being. Various studies into Home-Start show **significant changes in the long-term**: increased parental well-being; more positive parenting behavior; positive changes in participating children's behaviour with regard to rebellious, affective and fearful behavior; mothers with the most serious problems make the most progress.

[16] https://homestartworldwide.org/network/netherlands/

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who visit mothers for half a day once a week. Provision of social support by the volunteers is geared to increase maternal well-being. Increased maternal well-being is thought to result in more positive parenting behaviour, which in turn ought to lead to the reduction of behavioural problems in children. Previous evaluations of the Home-Start intervention in both the UK and The Netherlands have shown positive results such as increased maternal well-being and competence, improved social networks, and improved parenting behaviour' (ibid, p. 99).

Another problem solution, cited in the articles, is the counselling program CCD[17] (Lucas et al., 2017). 'Care for Child Development provides guidance to help caregivers build stronger relationships with young children and solve challenges in providing nurturing care. CCD encourages responsive caregiving in building relationships between caregivers and children. This includes sensitivity to children's movements, sounds and gestures and interpreting and responding appropriately to

Care for Child Development

Care for Child Development provides guidance **to help** caregivers build stronger relationships with young children and solve challenges in providing nurturing care. CCD encourages responsive caregiving in building relationships between caregivers and children. The CCD program **is state funded** in some countries (USA and Pakistan are such examples). CCD is a landmark and holistic ECD intervention that was originally **developed in the late 90s** as part of the regular child health visits as specified in the WHO/UNICEF strategy of Integrated Management of Childhood Illnesses (IMCI). The program is **currently in implementation** internationally. There is **no set criteria for enrolment**, the program has evolved into an approach integrated into existing social services in the different countries, targeted mainly towards vulnerable families. Therefore, low-income pregnant women are accessed by the program. **The interventions** include HV (3 to 4 visits in families with children up to 3 years old) involving integrated counselling on play and communication with counselling to improve child health, growth and development, including breastfeeding and complementary feeding, recognition of signs of illness, response to illness, prevention of illness and injury. CCD interventions **can improve** child development, growth and health, as well as responsive caregiving. It has also been reported to reduce maternal depression, a known risk factor for poor pregnancy outcomes and poor child health, growth and development. However, few countries have national policy support for integrating CCD into health or other services.

[17] https://sites.unicef.org/earlychildhood/index_68195.html

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them. Responsive caregiving is the basis for protecting children against injury, recognizing, and responding to illness, enriching learning, and building trust and social relationships. The concept has been applied also to 'responsive feeding', especially important for effective feeding of low weight or ill infants. In applying CCD, counsellors ask caregivers how they play and communicate with their children, how they get their children to smile and how they think their children are learning. The counselling aims to increase the time parents spend with their children and improve the quality of interactions that affect learning and health' (ibid, p. 42).

The universal HV models includes a specific program in the USA, which is the First Born Program[18] (Kilburn & Cannon, 2017). Also, other universal models across many different countries are studied. The participants in the First Born Program are 'generally mothers, can enrol during pregnancy up through the child's second month, and the program ends when the child reaches age 3. Services are free and voluntary, and all first-time families in a community are eligible to participate. The home visitor team includes a registered nurse or other licensed health care professional, who provides a postpartum home visit, delivers the medical components of the curriculum, and continues to participate in the home visits when families encounter medical challenges. The second member of the home visitor team is a parent educator who

First Born Program

The **goals of the program** include HV by which is achieved: promoting children's health and developmental outcomes and improving parenting in areas, such as breastfeeding, ensuring child safety, providing appropriate health care for the infant, promoting child development, developing nurturing relationships, and accessing needed community resources. The program is **both private and state funded**. First Born started in Silver City, New Mexico in 1997. It is **currently in implementation**. There are **no set criteria for enrolment**, since this is a universal HV program for first-time parents, therefore it is also **accessed equally** by low-income pregnant women and the rest of the population alike. Services include support, education, assessment, service coordination. The FBP model aims for **40 weekly home visits** in the child's first year of life, maybe less frequent in the second and third year. The universal program **reduced infant health care use** for high-risk and lower-risk families.

[18] https://firstbornprogram.org/

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generally has greater than a high school education and some human services experience. The manualized curriculum uses a 3-pronged approach to promoting child and family wellbeing that includes family education, identifying family challenges and making referrals to address them, and coordinating services available to families in the community. The goals of the program include promoting children's health and developmental outcomes and improving parenting in areas, such as breastfeeding, ensuring child safety, providing appropriate health care for the infant, promoting child development, developing nurturing relationships, and accessing needed community resources, and the topics covered in the visits reflect these goals' (Kilburn & Cannon, 2017, p. 3).

The other targeted HV program, focusing on children with disabilities, is reviewed in the article of McBride & Peterson (1997). 'Home visits are one mechanism for providing comprehensive services to young children with disabilities and their families, as required by Part H of the Individuals with Disabilities Education Act of 1990. Home visiting is a vehicle for delivering an array of comprehensive early intervention services needed by young children with disabilities and their families' (ibid, p. 209). 'The present study is a first attempt to document home-visiting

Family Connects program

The aim of the program is to improve child and family health and well-being at the population level via HV and dissemination of the FC model. Durham Connects **was piloted** in 2008 and is **currently in implementation**. It is state and private **funded**. The program is designed for **universal community coverage**, with the goal of at least 60-70 percent of eligible families participating. All families with newborns in a coverage area are eligible, whether the area is a region, state, city or neighborhood. **Engagement and scheduling for the home visit** ideally occurs face-to-face in the hospital post-delivery. Registered nurses provide health and psychosocial assessments of newborn, mother, and family with connection to community resources and offer with follow-up as needed. A key consideration to staffing is the program home, and replication sites have employed different options based on their communities such as health systems, county public health departments, and child-serving non-profits. FC is an **evidence-based model** that supports all families welcoming a new baby. When FC is implemented with high quality, research demonstrates that families are stronger, children's lives are enhanced, and communities save money.

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practices in a community-based service delivery system. The study is a descriptive investigation of the content and process of home visits by early childhood special educators (hereafter referred to as home interventionists) in early intervention programs in which homebased services were the primary mode of service delivery for children birth to 3 with disabilities and their families.' (ibid, p. 214).

Nurse-Family Partnership

NFP **works by** having specially trained nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy, and continuing through the child's second birthday. **The aims** of the program are to: improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets and reducing their use of cigarettes, alcohol and illegal substances; improve child health and development by helping parents provide responsible and competent care; improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work. The program is **state and private funded**. It was **launched** in 1996 and **is currently in implementation**. The NFP program model has been **proven effective through a** track record spanning more than 40-years of research, evidence, and implementation. NFP focuses on serving low-income women pregnant with their first child. Some of the evidence shows that 48% reduction in child abuse and neglect, 59% reduction in arrests among children, 72% fewer convictions of mothers, 56% reduction in emergency room visits for accidents and poisonings, 67% reduction in behavioral and intellectual.

Georgia's MIECHV program[19] is the focus of three of the articles (Lanier et al., 2015; Cho et al., 2018; Dodge et al., 2019) 'focuses on at-risk families with children up to age five, living in both rural and urban neighbourhoods. From January 2012 through September 2015, the program provided funding to community-based organizations in seven counties to implement three evidence-based home visiting models, Healthy Families America, Nurse-Family Partnership[20], and Parents as Teachers (the FC program is also MIECHV-approved)[21]. Each community-based organization implemented one or more of the HV models; in only one county were all three models available. Based on mothers' verbal

[19] https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview
[20] https://www.nursefamilypartnership.org/
[21] https://familyconnects.org/

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consent, contact information and screening data were given to the appropriate community-based organization for initial HV engagement activities. Mothers' written consent for receipt of services, gathering of ongoing screening and HV service-related data, and use of the data for performance monitoring were collected at the initial enrolment visit' (Cho et al., 2018, p. 591).

In addition, the article of Korfmacher examines many HV programs, among which are some of the already mentioned: 'Although there are many examples of evidence-based early childhood home-visiting programming, the field itself struggles with modest outcomes and variable levels of program effectiveness. This article documents the experience of creating a state-wide monitoring system to assess home-visiting program quality and compliance to identified standards, integrating multiple sources of information across different domains of functioning. Monitoring results from 57 programs are summarized, with variable but promising levels of quality' (Korfmacher et al., 2019: p. 380).

Maternal, Infant, and Early Childhood Home Visiting program

The MIECHV program, a national initiative **to expand access to HV and increase the evidence base around best practices in the field**, was **launched** in 2010 and is **currently in implementation**. This program **focuses on at-risk families** with children up to age five, living in both rural and urban neighbourhoods. The MIECHV program is state funded. Mothers potentially eligible for HV were screened through a First Steps program (a community-based service that connects families to community resources appropriate for expectant parents and children from birth to 5 years of age) and then referred to a HV program based on their **fit with eligibility criteria** and the availability of one of the three HV models in their community: **Healthy Families America, Nurse-Family Partnership and Parents as Teachers**. The **FC program** is also MIECHV-approved.

Home visits by a nurse, social worker, early childhood educator, or other trained professional during pregnancy and in the first years of a child's life helps prevent child abuse and neglect, supports positive parenting, improves maternal and child health, and promotes child development and school readiness.

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Conceptual framework

A specific **conceptual framework** is used in some of the articles. Such is the ecological framework for policy studies and theory about parenting behaviour. Different concepts have also been defined in the articles in this focal point of advocacy.

Some of the concepts, included, for instance, in the article of Korfmacher et al. (2019), are: fidelity, compliance, and quality.

Study design and methodology. Findings

The **study design, methodology and findings** are presented in a different way in the different articles, related to the purpose and conceptual framework.

Most researchers have employed a quantitative methodology, mostly secondary data analysis, but also randomized control trials and questionnaires. This means that sometimes the design is experimental and other – not. Samples are usually big, since the goal is to conduct a representative study. Some researchers have also employed a qualitative methodology, such as interviews and observations, as well as a mixed method approach with both quantitative and qualitative methods.

In the article of Ascher et al. (2008) **is collected self-reported and observational data**, involving two groups of families in the study design: intervention group (Home Start group), which received support from the Home Start program and a comparison group, consisting of families with similar risk factors as those of the other group. A questionnaire for self - completion was sent to participants. Therefore, the article uses a mixed method approach, consisting of both quantitative and qualitative methods. **The results** show a significant improvement in perceived parenting competence, but no effects on maternal depressive moods. None of the changes in child behaviour were significant such as a decrease in negative child behaviour, internalizing and externalizing behavioural problems and negativity, and an increase in positive child behaviour, such as child cooperativeness and prosocial behaviour.

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Another quantitative study is that of Lanier et al. (2015). 'This study was a **secondary data analysis** of the 2011/12 National Survey of Children Health' (ibid, p. 2148) It 'sought to estimate national - and state-level HV service use in the United States using a nationally representative survey' (ibid). **According to the findings**, 'children who tend to have greater needs are more likely to receive HV service's. At the same time, 'the perception of HV services as a public service intended for low-income, high-risk families creates stigma and impedes the broader use of this preventive health service' (ibid, p. 2150).

In the article of Lucas et al. (2017), 'the World Health Organization and UNICEF identified sites where CCD has been implemented and sustained. The sites were surveyed, and responses were followed up by phone interviews' (ibid, p. 41). Here, again**, both qualitative and quantitative methods** were implemented. **The findings** state that 'CCD had been integrated into existing services in diverse sectors in 19 countries and 23 sites, including child survival, health, nutrition, infant day care, early education, family and child protection and services for children with disabilities. Published and unpublished evaluations have found that CCD interventions can improve child development, growth and health, as well as responsive caregiving. It has also been reported to reduce maternal depression, a known risk factor for poor pregnancy outcomes and poor child health, growth and development' (ibid, p. 41).

Cho et al. (2018) chose a **quantitative methodology** as well. 'The sample included 1,024 mothers (primary caregivers, mean age 22.89 years) who participated in family support programmes. Primary caregivers, all of whom were biological mothers, reported their family's sociodemographic characteristics. These included mothers' age, race/ethnicity, relationship status with a main romantic partner, employment status, educational attainment, and annual household income. Mother's race/ethnicity was coded by three categories (White, Black, and Other) that were included as independent variables in the model, resulting in regression coefficients that were interpreted with reference to White. To capture both material and social components of family risk, we constructed a composite index of family risk by summing four dichotomous indicators, yielding an index that ranged from 0 to 4: mothers' relationship status,

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employment status, educational attainment, and poverty level' (ibid, p. 590). The authors **found that** 'higher sociodemographic risks, characterized by unstable romantic relationships, employment, low educational, and economic resources, were associated with less active home visiting engagement. Mothers who lived in communities with more challenging socio-economic contexts, such as communities that had a higher proportion of divorced/separated households, poor quality housing conditions, and residential mobility, demonstrated lower programme engagement. Community poverty and instability could have created guardedness among community residents, hindering mothers' intentions to enrol and remain engaged in home visiting programmes. It is also possible that reduced social capital and cohesion inhibited residents in the mothers' neighbourhoods from sharing positive values on engaged parenting behaviours, which in turn could have produced a less supportive atmosphere for engagement in family support programmes' (ibid, p. 596).

Dodge et al. (2019) also focused on experimental design, but they conducted their own randomized clinical trial. They conducted an independent evaluation through parent interviews and review of health and child protective service records, therefore this **is a mixed method study** of the FC program. **The findings** point to the fact that 'case records documented program penetration and quality. The primary outcome was child protective services investigations for maltreatment. Secondary outcomes were the number of sustained community connections, maternal mental health, parenting behaviour, infant well-childcare visits and maternal postpartum care compliance, and emergency health care utilization. Families assigned to the intervention had more community connections, fewer cases of maternal anxiety or depression, and fewer investigations for child abuse. The program penetrated a high proportion of the population. Nurses identified and addressed minor family needs for 52%of all possible cases, compared with 49% in the university trial. All 192 family members responded that they found the FC experience helpful' (ibid, p. 1).

The article of Korfmacher et al. (2019, p. 381) 'documents the experience of creating a statewide monitoring system to assess home-visiting program quality and compliance to identified

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standards, integrating multiple sources of information across different domains of functioning. **Monitoring results from 57 programs** are summarized, with variable but promising levels of quality'. The authors **have found that** 'programs generally report satisfaction and benefit from the process. In addition, the relationship between direct observations of home visits and home-visitor report of their approach to working with families is analysed. Results suggest significant, albeit small, associations' (ibid, p. 380).

Additionally, Kilburn & Cannon's study (2016, p. 1) 'was a randomized controlled clinical trial of an intensive home visiting program' (the First Born program) 'delivered in homes of primary caregivers and their first-born children in Santa Fe, New Mexico. Intention-to-treat and contamination-adjusted intention-to-treat models were estimated, and 244 primary caregivers participated in the survey.' **Findings** point to children being 'one-third less likely to visit the emergency department in their first year of life and 41% less likely to have visited a primary care provider ≥9 times. The program reduced infant health care use for high-risk and lower-risk families. Children in families randomly assigned to the program had less health care use in their first year, demonstrating that a universal prevention home visiting model delivered by a nurse–parent educator team can reduce infant health care use. Lower-risk families also benefit from the program' (ibid, p.1).

The article of McBride & Peterson (1997) is the only one, based on a solely qualitative approach. Observations and interviews were conducted, 'describing the content addressed and the processes employed by early childhood special educators during home visits with children with disabilities, birth to 3 years of age, and their families. Multiple data collection strategies, including observation of visits, home interventionist self-report measures, and interviews with both home interventionists and families, were utilized to describe home visits' (ibid, p. 209). The article of McBride & Peterson (1997), aiming to explore the extent to which home visits are individualized for various children and families with a focus on children with disabilities, reveals 'that a model of child-focused intervention was most frequently implemented. Some evidence was found to indicate that the content of home visits was more likely to focus on the child when family

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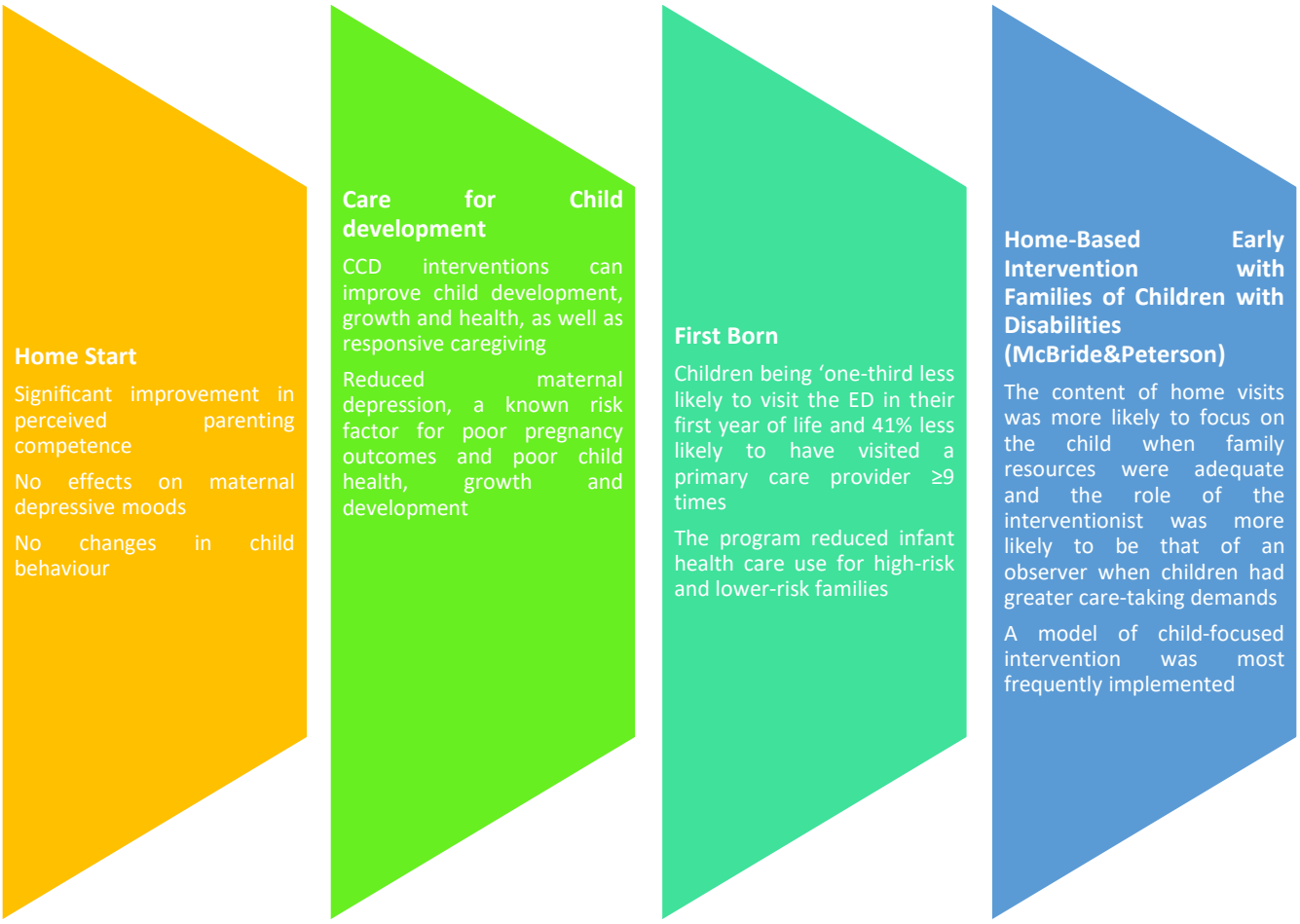
resources were adequate, and that the role of the interventionist was more likely to be that of an observer when children had greater care-taking demands' (ibid, p. 209).

Figure 5 Findings regarding HV programs



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Maternal, Infant, and Early Childhood Home Visiting - Nurse-Family Partnership

- The article focuses on the at-risk families' access to three HV programs, among which is the NFP program. According to the findigs, children with greater needs are more likely to receive HV services
- In addition, mothers who live in communities that have a higher proportion of residents that did not finish high school demonstrated relatively higher programme engagement.

Examining program quality in early childhood home visiting: From infrastructure to relationships (Korfmacher et al.)

- Programs generally report satisfaction and benefit from the process.
- The relationship between direct observations of home visits and home-visitor report of their approach to working with families is analysed. Results suggest significant, albeit small, associations

Family connects

- Program penetration in a high proportion of population and high quality
- The primary outcome was child protective services investigations for maltreatment
- More community connections, fewer cases of maternal anxiety or depression and fewer investigations for child abuse
- All mothers in the research responded that the program was helpful

Recommendations in the articles

Recommendations were found in eight. In the article of Lucas et al. (2018), 'using CCD, providers across health, nutrition, education, early child development and child and social protection can provide greater support for child development within their services. Because the earliest years in a child's life are the most formative, however, integrating CCD into health services that span from conception through pregnancy, childbirth and early childhood is an opportunity that should not be missed' (ibid, p. 47).

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The recommendations of Kilburn & Cannon (2017) are that it is possible to prevent costly health care use by using a staffing model that does not rely exclusively on nurses, which are scarce in some locations and also cost more than parent educator home visitors.

In McBride & Peterson's view (1997, p. 229) 'if families, rather than professionals, provide continuity in a child's life, expansion of the intervention focus to the family and attention to the parent-child relationship during home visits would be desirable'. It is necessary to have a clear philosophic framework for working with families of children with disabilities and caregivers need to be recognised as agents of change. In addition, training for caregivers is necessary. More broad-based, family-centred, and relationship-focused interventions are needed since both families and the processes of intervention are extremely complex. 'Given this, as well as interventionists' expressed frustrations and need for additional training, clinical supervision and support for home interventionists on an ongoing basis are clearly needed. Only by receiving supportive supervision, feedback, and opportunities for self-reflection will interventionists remain committed and able to implement new frameworks for providing services' (ibid, p. 230). Also, 'additional research is needed to examine how the content addressed and processes employed during home visits relate to outcomes for individual families and children. Multiple data collection methods must be undertaken to allow examination of additional variables related to the characteristics of interventions, including the theoretical orientations guiding intervention, the integrity with which intervention strategies are implemented, the differential effects of various amounts and types of training, and the relationship between the home interventionist and the family' (ibid).

According to the recommendations in the article of Cho et al. (2018, p. 597), 'the opportunity exists to adapt and tailor home visiting delivery to better fit with the realities of the families and communities served. As shown in other fields, greater matching of intervention processes and outcomes to individuals' preferences has been associated with both improved subjective and objective results (Schaarschmidt et al., 2011). For example, rather than uniformly implementing home visiting programmes across several communities, home visiting organizations may better

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serve their communities by allocating their resources in more flexible ways, through variation in programme models offered (e.g., both short-term and long-term models), staffing (e.g., including second-shift and weekend staff who provide services in the evening and outside of the standard workweek), and modes of service delivery (e.g., creating resident home visiting programmes in day-care centres)'.

Lanier et al. (2015, p. 2157) recommend that 'the state-level finding that children in states with higher levels of poverty (and fewer public resources) are less likely to receive a HV suggests policy makers should consider allocating additional resources to these states to provide HV services to children in greatest need. Therefore, increasing the level of HV services available in the continuum of services available in the community will likely benefit child health and well-being.'

In Korfmacher et al.'s opinion (2019) there is need to use monitoring findings to support home-visiting programs, since this holds potential for quality improvement.

According to Dodge et al. (2019, p. 9), it is necessary to achieve 'continued dissemination of this public health program in new communities when accompanied by ongoing implementation evaluation and, when possible, impact evaluation'.

The review of the articles shows a big variety of HV programs. Although they have specifics, all of these programs have common components such as provision in the home of the client, integrated approach, the service providers vary from volunteers to prepared specialists, who have received respective training. The approach is always flexible according to the needs of beneficiaries. There is a high level of accessibility (the service finds the client and vice versa) and availability (in many municipalities/states, close to the beneficiaries). Evidence base regarding the effectiveness, cost-effectiveness, impact, sustainability, as well as monitoring data, etc. is regularly collected and analysed and the published reports are used as basis for further development of the HV programs. Most of the programs have both state and private funding. In general, the recommendations centre around the following: expand implementation of CCD services for at-risk families; well-designed evaluation to formulate the

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optimal home visits; proactive outreach and recruitment strategies; use a staffing model in home-visiting that does not rely exclusively on nurses; use of monitoring findings to support HV programs; increasing the HV services available in the continuum of services; funds should be allocated to state with more children at greater need.

5.2.2. Services in support of early learning of children aged to three

Overview of the articles

Ten research-based articles were reviewed in the focal advocacy point services in support of early learning of children aged to three. Some of the articles are related to identified practices from the I part of the research as Sure start, Home start, Toys for inclusion, Community mothers, etc., as well as additional practices related to this focal point of advocacy. The data from the analysis shows that most articles are related to Sure start practices in the UK, which are broadly investigated and presented in the articles through different aspects. This practice is evaluated often and systematically and used for program modification focusing more on quality childcare and parent support. The research shows absence of data and articles present Sure start Children houses in Hungary, which is one of the practices, included in the first part of the report. The same absence of scientific evidence is related to Toys for inclusion, probably because the project is still in its implementation phase. This lack of data made it necessary to include information about programs, such as the Abecedarian Project USA and Early Head program USA, which have been researched over the last years. The key demographic characteristics about the articles are presented in table 5.

Table 5 Articles in the focal point of advocacy 'Services in support of early learning of children aged to three'

№	Author/s & year of publication	Publication details and link to abstract or full text (if available)	Country/state of study and/or program implementation
1	Asscher,J. et al. (2008)	Asscher, J. J., Hermanns, J. M., & Deković, M. (2008), Effectiveness of the Home-Start parenting support program: Behavioral outcomes for parents and children. Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health, 29(2), 95-113.	The Netherlands

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2	Belsky, J. et al. (2008)	Belsky, J., Melhuish, E., & Barnes, J. (2008), Research and policy in developing an early years' initiative: the case of Sure Start. International Journal of Child Care and Education Policy, 2(2), 1-13. https://ijccep.springeropen.com/articles/10.1007/2288-6729-2-2-1 (full text)	UK
3	Cortellesi, G. (2016)	Cortellesi, G., & Kernan, M. (2016), Together old and young: How informal contact between young children and older people can lead to intergenerational solidarity. Studia paedagogica, 21(2), 101-116. https://www.researchgate.net/publication/306243321_Together_Old_and_Young_How_Informal_Contact_between_Young_Children_and_Older_People_Can_Lead_to_Intergenerational_Solidarity (full text)	EU
4	Hutchings, J. et al. (2007)	Hutchings, J., Bywater, T., Daley, D., Gardner, F., Whitaker, C., Jones, K., ... & Edwards, R. T. (2007), Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomized controlled trial. BMJ online, 334(7595), 678. https://www.researchgate.net/publication/6456009_Parenting_intervention_in_Sure_Start_services_for_children_at_risk_of_developing_conduct_disorder_pragmatic_randomised_controlled_trial_vol_334_pg_678_2007 (full text)	Wales
5	Love, J. et al. (2005)	Love, J. M., Kisker, E. E., Ross, C., Raikes, H., Constantine, J., Boller, K., ... & Fuligni, A. S. (2005),The effectiveness of Early head start for 3-year-old children and their parents: lessons for policy and programs. Developmental psychology, 41(6), 885 https://www.apa.org/pubs/journals/releases/dev-416885.pdf (full text)	USA
6	Melhuish, E. et al. (2008)	Melhuish, E., Belsky, J., Leyland, A. H., Barnes, J., & National Evaluation of Sure Start Research Team. (2008), Effects of fully-established Sure Start Local Programmes on 3-year-old children and their families living in England: a quasi-experimental observational study. The Lancet, 372(9650), 1641-1647 https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(08)61687-6.pdf (full text)	UK
7	Melhuish et al. (2015)	Melhuish, E., Ereky-Stevens, K., Petrogiannis, K., Ariescu, A., Penderi, E., Rentzou, K., ... & Leseman, P. (2015), A review of research on the effects of Early Childhood Education and Care (ECEC) upon child development. https://ecec-care.org/fileadmin/careproject/Publications/reports/CARE_WP4_D4__1_review_of_effects_of_ecec.pdf (full text)	International
8	Morrison, J. et al. (2017)	Morrison, J., Pikhart, H., & Goldblatt, P. (2017),Interventions to reduce inequalities in health and early child development in Europe from a qualitative perspective. International journal for equity in health, 16(1), 87. https://www.researchgate.net/publication/317300747_Interventions_to_reduce_inequalities_in_health_and_early_child_development_in_Europe_from_a_qualitative_perspective (full text)	EU
9	O'Connor (2001)	Supporting mothers: Issues in a community mothers programme. Community, Work & Family, 4(1), 63-85. https://www.researchgate.net/publication/45229888_'Supporting_mothers_Issues_in_a_Community_Mothers_Programme'_Community_Work_and_Family_2001_4_1_63-85 (full text)	Ireland

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10	Ramey, C. T et al. (2001)	Ramey, C. T., Campbell, F. A., Burchinal, M., Skinner, M. L., Gardner, D. M., & Ramey, S. L. (2000), Persistent effects of early childhood education on high-risk children and their mothers. Applied developmental science, 4(1), 2-14 http://www.web.pdx.edu/~stipakb/download/PA555/EarlyChildhoodEducStudy.pdf (full text)	USA

The main demographic characteristics of the articles include **country (countries), in which the program is implemented, target group(s), year of the study, who conducted the research**. The countries of the evidence-based policies from the articles are the following: UK, USA, The Netherlands, North Ireland, Czech Republic. When it comes to the target group, the analysis shows that target groups are: low-income families, with children 0 to 3, who face daily challenges, due to their socioeconomic circumstances; children living in disadvantaged neighbourhoods; mothers after child birth, participating in supportive programs, implemented in different countries. The years of publishing of the articles are in the period between 2000– 2017. All the articles are based on research, conducted by public universities. One review is part of a report regarding the Impact of ECEC in the short, medium & long-term. This review has resulted from a collaborative project between universities in The Netherlands and UK.

Main identified problems and purposes of the articles

The main problems, targeted in most of the articles, relate to exploring effective European programs for disadvantaged children. Many families who face daily challenges, due to their socioeconomic circumstances, are not able to create the necessary nurturing environments for their children (Morison et al., 2017). Moreover, there is evidence of an intergenerational transmission of inequity and poor health, which is greater among children of mothers with low education (ibid, p.2). Ramey at al., (2000) define intergenerational poverty as 'pernicious' and point to the fact that impairments in cognitive development, school performance, and social competence are associated with growing up poor.

The existence of a cycle of disadvantage for children from poor families is a problem that is found in UK where the Sure start has been developed (Belski at al.,2008). 'Using statistics from the Indices of Multiple Deprivation (Office of the Deputy Prime Minister, 2004), the National

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Evaluation of Sure Start (NESS) calculated that for children in families with an income 60% or less than the national median (official poverty line), 51% of all such poor children live in the 20% most deprived areas and 65% live within the 30% most deprived areas (ibid, p. 4).

Asscher et al., (2008) who research the effectiveness of the Home start program, emphasize on the difficulties that parents with young children experience. The parents are overwhelmed by their experiences, as well as changes and demands, associated with their parenting role, which go beyond their own possibilities. At the same time, the degree, to which mothers experience parenting as being difficult and unsatisfactory is one of the most important factors, which influence child wellbeing.

The pressure of child rearing, which parents experience, especially those from disadvantaged communities, is a problem stated in the article of O'Connor (2001) who studies the practice of Community mothers in North Ireland. 'Roughly half of the recipients and just under three quarters of the providers graphically described strong negative feelings when they came home from hospital with their new baby and started the daily care, isolated from social and professional life.' (O'Connor, 2001, p. 14)

Hutchings et al. (2007), who have explored the effect of programs for parents of children at risk with conduct disorders in Sure start UK, discuss the issue of antisocial behaviour in young people as a growing problem. Higher rates occur in single parent families and families with frequent changes of parental figures and parental substance misuse, psychopathology, marital problems, and poor parenting skills. The lack or inconsistency of use of key parenting skills leads to conduct disorders and problematic behaviours. The authors emphasize on the fact that early onset behavioural problems such as aggression and non-compliance are the best predictors of antisocial and criminal behaviour in adolescence and adulthood (ibid, p.1).

In an article, based on findings of the European project called Together Old and Young (TOY), which was designed to research and develop good practices in intergenerational learning involving young children and older people, Cortellesi et Kernan (2016) pose a problem, connected with intergenerational communication. 'Today's young children need relational and collective

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dispositions, not individualistic ones, to equip them to live well in the increasingly complex, interconnected, and boundary-blurred 21st century world.' (ibid, p 102.)

The problems, reviewed in the articles, are related to intergenerational transmission of inequity, disadvantaged children in rural areas, parental overwhelming and child rearing. In general, the issues in these articles are related to problems in the families and parental upbringing, which is probably due to the age of the children (0-3), when children are mostly looked after in a family environment. Therefore, the wellbeing of the parents directly affects children's wellbeing.

In addition to that, there is an identified body of evidence pointing towards the **significance of the problems,** reviewed in the articles. Morison (2017) studies lifelong inequalities, starting before birth and accumulating across the life course. The analysis of inequalities across cohorts from 12 European countries illustrates intergenerational transmission of inequity and poor health of children of mothers with low education. It is important to point out that some programs have a larger scope. The significance of the problem, according to Melhuish et al., (2008) is due to the fact that Sure start Local programs (SSLPs) UK are targeted to 20% of the most deprived areas in England. The programs are managed by the health, education, social services, and voluntary sectors at the same time. In the view of Love (2005), the significance of the Early head start (EHS) Federal program is related to the fact that it began with 68 grantees funded by the Administration on Children, Youth, and Families (ACYF) in the U.S. Department of Health and Human Services (USDHHS), and it has grown to more than 700 programs that, in 2004, served 62,000 low-income families with infants and toddlers throughout the country. (ibid, p. 886).

According to O'Connor, (2001), who researches the effects of the program Community mothers, there is an increasing concern about the adequacy of traditional support for parenting in the face of a dramatic rise in married women's participation in (largely full time) paid employment; dramatic increases in marital separation and an increasing awareness about domestic violence and sexual abuse in the family. (ibid, p.5)

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According to Hutchings (2007), who researches the topic of conduct disorders in the UK and USA, about 5-10% of children, aged 5-15, have clinically important conduct disorders. Up to 20% of children in disadvantaged areas have conduct disorders and, when untreated, up to 40% of children with early difficulties develop subsequent conduct disorders, including drug misuse and criminal and violent behaviour. (ibid, p.1)

In summary, it is important to point out, as most of reviewed articles connect problems in early childhood learning and lifelong inequalities starting before birth and accumulating across the life course.

The **purposes** of most of the studies are related to studying the effects of programs: Sure start, EHS, Home start, Community mothers, Abecederian project, other (5) early childhood programs, which improved child development in Europe. In addition, there is one article, which is a review of research on the effects of ECEC on child development. Another article studies how IGL in non-formal and formal settings supports the wellbeing of older adults and young children.

Problem solutions

The **problem solutions** are related to several programs, implemented in different countries, which were already mentioned above. The Community mothers program[22] aims 'to improve the parent's capacity to rear, educate and provide emotional support to children by enhancing the self-esteem and

Community Mothers

The Community Mothers Programs in Ireland is spread across 9 centers with approximately 7 coordinators and 97 Community Mothers supporting over 2,500 families per year through **home visits and group meetings**. They reach out to the communities and provide valuable resources through **parenting groups, provision of information, antenatal classes and a variety of other similar services.** One Community Mother described the impact in the report *'It is really important* ***to start building links with the community and using community resources, they really become integrated into the community…they make friends for life'***. The response from parents was equally as positive around the impact it had both personally and on the community with one stating *'The home visiting is crucial – all services should be based in the home and the community'.*

[22] https://www.communityfoundation.ie/insights/news/community-mothers-programme-review-launch

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confidence of the parents. It is similar to that in other domiciliary care services (such as the Home help service) in the context of low-paid/volunteering (O'Connor, 2001, p. 4)

The Home Start Program[23] is one of the various programs, designed to support parents with young children (you can see more information about this integrated type of program in the previous part 5.1.2 under heading problem solutions). The program works with volunteers who visit mothers for half a day once a week. Provision of social support by the volunteers is geared to increase maternal well-being. Increased maternal well-being is thought to result in more positive parenting behaviour, which in turn ought to lead to the reduction of behavioural problems in children. (Asscher et al., 2008)

SSLP UK [24] aims to improve health and wellbeing of young children, living in disadvantaged neighbourhoods by preventing the transmission of inequalities in health, poverty, school failure, and social exclusion between generations. SSLPs were set up between 1999 and 2003 to develop different ways of providing services in deprived communities. The original programs were area based, with all young children and their families living in a prescribed geographic area being the targets of the intervention. SSLPs have evolved, changing their model of service delivery by becoming Sure Start Children's Centres during 2004–2006. The changes include clearer specification of services, with a strong emphasis on child wellbeing and the need to reach the most vulnerable,

Sure Start

The aims of the program are to improve health and wellbeing of young children, living in disadvantaged neighborhoods. State funded from 1993. The program transformed in Sure Strat Children's centers with specific services and still operates. The **criteria for enrolment in the program** are all children in prescribed disadvantaged areas. The program **is managed by** a partnership of health, education, social services, and voluntary sectors at the local level. Children in the SSLP areas **showed better social development** and more positive social behaviour. Families showed less negative parenting and provided a better home-learning environment.

[23] https://homestartworldwide.org/
[24] https://www.education-ni.gov.uk/articles/sure-start

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and adjustment of service provision to the degree of family disadvantage (Melhuish et al.,2008). Sure start Children houses, Hungary, was developed to support children and their families to reduce health inequalities in the most deprived regions (Morrison et al., 2017). The program aims to reach families from diverse backgrounds to promote integration of disadvantaged and/or minority (mostly Roma) children and their parents into the community. It establishes cooperation with local services focusing on strengthening parenting capacities and providing advice and support for women seeking employment.

Toybox[25] from Northern Ireland is an intervention aimed at reaching out to traveller families to enhance the social, educational, emotional, physical, language and cognitive development of children. By supporting and empowering parents to develop their educational skills, parents participated in children's learning with positive, non-violent parenting. The intervention was delivered in the family home following individualized plans developed with parents. An objective was to establish trust-based relationships with parents and encourage them to become involved in community activities as a support mechanism (Morrison et al., 2017).

Toybox

The Toybox Project is a rights-based service development model which aims to significantly reduce social and educational inequalities experienced by young Traveller children through an outreach play-based early intervention service provided in partnership with children and parents. Early Years 'the organisation for young children (formerly NIPPA), is responsible for the operational implementation of the project.

Travellers are a distinct ethnic group within Irish society. Their lifestyle and culture, based on a nomadic tradition, sets them apart from the settled population. They are widely acknowledged as one of the most marginalized and disadvantaged groups in Irish society. While many Travellers still live in trailers, some Travellers now live in settled accommodation.

EHS[26] is a two-generation intervention program serving parents and children from birth to age three, targeted towards disadvantaged communities. It began in 1995 and by 2003 had grown to

[25] https://www.childcareexchange.com/article/the-toybox-project-belfast-northern-ireland/5018782/
[26] https://eclkc.ohs.acf.hhs.gov/programs/article/early-head-start-programs

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over 700 programs serving more than 62,000 children in the US. EHS aims to promote children's development and provides childcare, developmental assessments, health, and parenting services. There are three models of intervention: centre-based, HV, and a combination of these two. (Love at al., 2005)

The **Abecedarian Project**[27] involves a poor African American population in North Carolina, (Melhuish et al., 2015). Children in the program receive full-time, high-quality educational intervention in a childcare setting from infancy through age 5. Each child has an individualized prescription of educational 'games' incorporated into the day. These activities focus on social, emotional, and cognitive areas of development, but have a particular emphasis on language.

Abecederian Project

FPG's Abecedarian Project represented a revolutionary approach in early childhood education. It differed from other childhood intervention projects because it began in early infancy and exposed children to a high-quality child care setting for five years—the entire period from birth through school entry—instead of the shorter durations typical of other projects. **It was founded in** 1970 in USA. Poor Afro American in North Carolina are ensured access to the program. Criteria for enrolment includes: the last year of school completed by both parents; family income; family's social history. The i**nterventions** include full-time, high-quality educational in a childcare setting from infancy through age 5; individualized prescription of educational 'games' incorporated into the day; medical care. There is **short- and long-term impact** on children's development.

Conceptual framework

The **conceptual framework**, used in the articles, is diverse. In the article of Asscher et al., (2008), regarding Home start, it is stated that 'through social support parenting interventions providing social support, one may influence a parent's sense of competence and feelings of self-efficacy and, in turn, his or her parenting behaviour'. In the article, regarding the Abecedarian preschool program, is used the developmental systems theory (Bertalanffy, 1975), which articulates the

[27] https://abc.fpg.unc.edu/abecedarian-project

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role of a stimulus-rich, positive, responsive social environment in facilitating instrumental and conceptual learning (Ramey et al, 2000).

Study design and methodology. Findings

The **study design and methodology** are presented in a different way in the different articles, related to the purpose and conceptual framework.

The main characteristics of the study designs and methodologies of the articles are that the targeted programs have their own monitoring systems. Both qualitative and quantitative information have been collected. Usually, quasi-experimental design has been used in order to evaluate the level of effectiveness and impact.

In the article, based on 5 practices in Europe (Morrison et al., 2017), is used **a study design**, based on a mix of qualitative and quantitative methods – interviews and surveys. **The findings** from a study on the Sure Start Program in Hungary (Morrison et al., 2017) points to improved self-esteem, job seeking, self-confidence and parent's relationship with their children as a result of Sure Start's parenting classes, in combination with self - help groups and personal consultations. Every child's development was assessed and monitored. Additionally, as it was mentioned above, Morrison also studies the effects of the Toy BOX - North Ireland. 'Participants described programmes, which aimed to provide activities to stimulate children's learning through structured play and which provided support and assistance for parents. In these programmes, parents were actively involved in activities. Parents and staff referred to establishing long-term trust-based relationships as a key element for programmes to improve parents' self-esteem and reduce their stress levels, which in turn helped improve their children's development. According to staff and parents, this improved parents' capacities and fostered positive parenting, which helped them assist in their children's learning and development' (ibid, p.1).

Regarding the Home Start program, **an experimental study** design was implemented, using self-reported and observational data, collected in two waves, from 54 mothers and their children

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between 1.5 and 3.5 years of age, who participated in this intervention program for 6 months (Asscher at al., 2008). The **findings** in this article point to some kind of benefits for the parents and children who are target groups of the programs. Home-Start appears to influence maternal-perceived competence – 'mothers in the program reported increased well-being. It seems that Home-Start's philosophy (that mothers, in principle, are capable of caring for their children) and the Home-Start approach (in which mothers are given advice only when they themselves have asked for it) increase maternal self-esteem. The study shows that positive changes were achieved in maternal competence and in two aspects of positive parenting behaviour. Parental consistency and observed sensitivity improved significantly' (Asscher et al., 2008, p.106). Well-being might have increased because mothers felt relieved as the volunteers carried out certain tasks (e.g., domestic tasks, shopping, taking care of the children) for them. Also, mothers might be relieved by the emotional support that the volunteers offer through listening, and if asked, through practical advice (ibid, p. 106).

In the article, regarding Sure start, **the study design** is experimental, and the methodology includes a survey with parents, as well as observations. (Hutchings et al., 2007). **The finding** in from this community-based study on the Sure Start program is that the evidence-based parenting intervention delivered with fidelity by regular Sure Start staff is effective (ibid). At follow-up, most of the measures of parenting and problem behaviour in children showed significant improvement in the intervention group (ibid). Moreover, the Incredible Years basic parenting programme, which is a part of the Sure Start Program, 'effectively increases positive parenting practices and reduces antisocial behaviour in children at risk of developing conduct disorder' (ibid, p.6).

The EHS article points to a **similar study design and methodology** (Love et al., 2005). **The findings show** that programs combining home visitation with centre-based care have been more effective across a wider range of outcomes than programs using one of these approaches. 'Early Head Start parents were more emotionally supportive, provided more language and learning stimulation, read to their children more, and spanked them less' (ibid, p.885). In addition, 'three-year-old children in the program performed better than the control group of children in cognitive and

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language development, displayed higher emotional engagement of the parent and sustained attention when playing with objects, and had a lower level of aggressive behaviour' (ibid, p. 885). The findings also show a greater impact for children and parents attending the mixed-approach programs, which combined home- and centre-based services. In a review article. Melhuish et al. (2015) point several important findings regarding the EHS program. He states that, 'whenever parents were enrolled in EHS during pregnancy, there was a stronger impact. The effects of EHS were strongest for families with a moderate number of demographic risks (three out of five) rather than low or high risk, but there were no significant impacts upon the highest risk families who seemed impermeable to this intervention. Centre-based programs had the strongest effects on child outcomes, whereas home-based programs had the strongest effects on parenting outcomes' (ibid, p. 14). Melhuish confirms the already commented finding that the mixed model combining both centre-based provision with HV had the most wide-ranging and strongest positive impact.

The study of Melhuish et al., (2008) uses **a quasi-experimental design**, comparing 5 883 3-year-old children and their families from 93 disadvantaged SSLP areas with 1879 3-year-old children and their families from 72 similarly deprived areas. The outcomes that were measured, include: children's immunisations, accidents, language development, positive and negative social behaviours, and independence; parenting risk; home-learning environment; father's involvement; maternal smoking, body-mass index, and life satisfaction; family's service use; and mother's rating of area. (ibid, p. 1641). **The finding** from this experimental study shows that Children in the SSLP areas showed better social development than those in the non-SSLP areas, with more positive social behavior and families in SSLP areas showed less negative parenting. These families used more services for supporting child and family development than those not living in SSLP areas.

The same program is studied **in a review article** of Belsky at al. He emphasises that 'Sure Start Local Programmes were part of a revolution in services initiated by the New Labour government when it came to power in 1997. It sought to enhance numerous facets of communities and in

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ways that would not stigmatise children and families in need' (Belsky et al., 2008, p.11) **The findings** in the article point to the fact that 'children in the Sure Start Local programs areas showed better social development than those in the non-SSLP areas, with more positive social behaviour' (ibid, p.). Also, 'families in SSLP areas showed less negative parenting and provided a better home-learning environment; these families used more services for supporting child and family development than those not living in SSLP areas. Effects of SSLPs seemed to apply to all subpopulations and SSLP areas' (ibid, p.10). In addition, the SSLP increases positive parenting practices and reduces antisocial behaviour in children at risk.

The **study design** for the Abecedarian Project is also experimental and longitudinal and includes three randomized intervention conditions for at-risk participants, compared to a control condition. The 111 children, whose mothers had a low IQ and low-income, were randomised into two groups. One group was placed in a program involving centre-based care and home visits from three months of age and continuing until children entered school. The control group received family support, social services, low-cost or free paediatric care, and child nutritional supplements but no additional childcare beyond what the parents and the local services provided. (Melhuish et al, 20015, p.15). Melhuish presents one of project impact connected with children who started participation during infancy until they enrolled at school, received care and early quality education. 104 of the original 111 participants were measured by age 21. The **RCT revealed that** the program group, as compared with the control group, showed gains in cognitive functioning, academic skills, educational attainment, employment, parenthood, and social adjustment. Therefore, 'the earlier the start, the greater the effect' (ibid, p. 15) 'What's more, the likelihood of retention in grade during primary school declined by almost 50 per cent for children from the program. Also, the mothers in the intervention group became better educated and were more likely to become employed, hence both generations benefited' (ibid, p. 15). In the same review Belsky et al. (2008) emphases that the 'influential' American Abecedarian Project demonstrates clear benefits for disadvantaged children when started in infancy, since there is high-quality childcare provision.

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Moreover, according to Campbell et al. (2000), the Abecedarian project, consisting of a preschool intervention, reduced the incidence of delayed cognitive development. 'The most vulnerable children benefitted the most from the preschool program. Teen mothers of children receiving the centre-based preschool program had an increased likelihood of completing high school and obtaining postsecondary training. The Abecedarian Project also brought unmistakable advantages for the teenage mothers with children in the study. By the time their children were 4½ years old, these mothers were more likely to have finished high school and undergone post-secondary training, more likely to be self-supporting, and less likely to have more children' (Campbell et al., 2000, p. 122). The Abecedarian project has effects on children's progress at school over time. 'Researchers monitored this progress with follow-up studies conducted at ages 12, 15, 21, 30, and 35. The findings continue to demonstrate that important, long-lasting benefits are associated with the high-quality early childhood program.'[28] 'Through age 15, I.Q. scores for the children who received the birth-to-age-5 Abecedarian intervention were higher than those of the randomly assigned control group. The Abecedarian children also scored higher on achievement tests in math and reading during their elementary and secondary school years. In addition, they had lower levels of grade retention and fewer placements in special education classes.'[29] 'At age 21, the treated group had maintained statistically significant advantages both in intellectual test performance and in scores on academic tests of reading and mathematics, and the treated group also had attained more years of education. In addition, recipients of the Abecedarian curriculum were more likely to attend a 4-year college or university, more likely either to be in school or to have a skilled job, or both. They also were less likely to be teen parents, less likely to smoke marijuana, and less likely to report depressive symptoms, when compared to individuals in the control group.'[30]

In **his review study** about **Community mothers** program, O'Connor **points out that** the program has a positive effect according to the majority of those who said that they had received the

[28] https://abc.fpg.unc.edu/abecedarian-project
[29] https://abc.fpg.unc.edu/abecedarian-project
[30] ibid

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Programme (72%) and of those who provided it (82%) (O'Connor, 2001). 'Two thirds of the providers spontaneously referred to its effect on their confidence; two fifths of the recipients spontaneously referred to its effect on their self-esteem and security and more than one third of the recipients referred to its impact on their sense of calm and ability to relax. Roughly three fifths of both the providers and the recipients said that it had impacted on the parenting abilities' (ibid, p. 16). The Community mothers program **has a positive effect** according to the majority of those who said that they had received the Programme (72%) and of those who provided it (82%) (O'Connor, 2001). 'Two thirds of the providers spontaneously referred to its effect on their confidence; two fifths of the recipients spontaneously referred to its effect on their self-esteem and security and more than one third of the recipients referred to its impact on their sense of calm and ability to relax. Roughly three fifths of both the providers and the recipients said that it had impacted on the parenting abilities' (ibid, p. 16)

In the article of Cortellesi et al. (2016, p.109), **another review** of Toy for inclusion project and intergenerational theory, it is **found that** 'the wellbeing of children in intergenerational contact was enhanced by the opportunity to be in contact with older people on a regular basis, enjoying the slow pace of this relationship compared to the high-speed daily life they often have with their parents, and learning about the past, traditions, and old games.' **The findings** point to the fact that 'the wellbeing of children in intergenerational contact was enhanced by the opportunity to be in contact with older people on a regular basis, enjoying the slow pace of this relationship compared to the high-speed daily life they often have with their parents, and learning about the past, traditions, and old games' (ibid).

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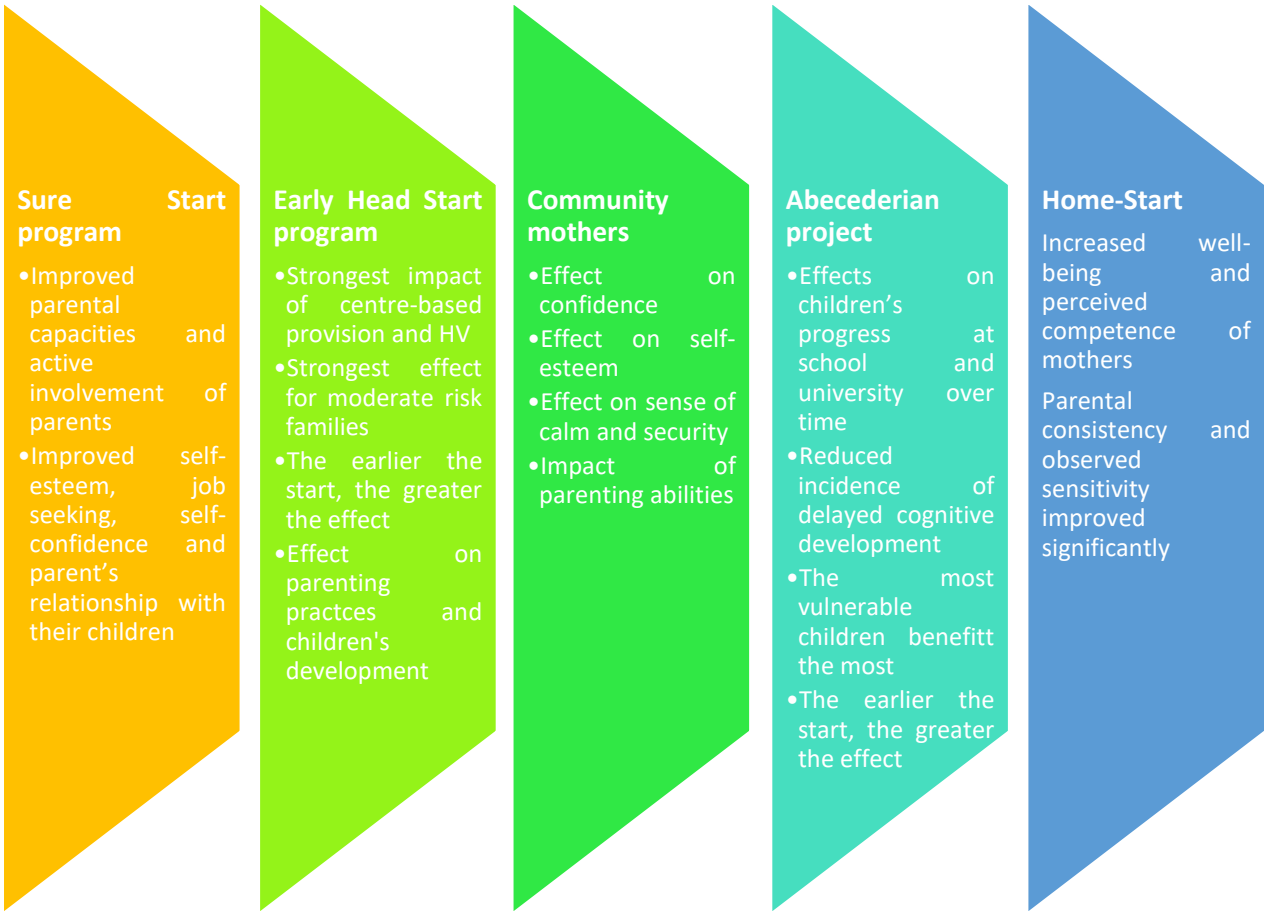
Figure 6 Findings from the articles



Recommendations in the articles

The recommendations in the analysed studies vary in terms of scope. As a result of the recommendations in the article of Belsky (2008), there is an improvement of policy. The government took on board the findings from the first phase of independent impact evaluation of Sure start, and modified the programme, focusing more on quality childcare and parent support via Children's Centres. The change seems to be yielding benefits. Belsky (2008, p.11), emphasise that when governments make reforms, they have to be *'ever ready to revise, learning even hard lessons, should always be the order of the day and always best to adopt a more experimental approach and one with an intervention clearly defined, or even manualised, rather than one that articulates philosophy and goals mostly, and far less so the means for achieving them'.*

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According to Hutching (2007), these results have already had impact within Wales, where the Welsh Assembly government have funded training in the program across Wales as part of its parenting action plan. The authors' view the government must commission effective services for children at high risk of conduct disorders. They evidence-based programmes decrease the high cost the society pay for social survive and antisocial behaviour which is possible results from conduct disorders.

In Morrison et al.'s view (2017, p.6), 'while focusing on parenting is important, it is also necessary to address the conditions of daily life, which makes positive parenting difficult. This requires policies aimed at children through an explicit, multi-dimensional and integrated strategy and investment in reducing child poverty and improved living conditions.' The authors state that it is important to provide access to a comprehensive range of quality early year services in order to reduce inequalities during the early development of children, especially for those from disadvantaged backgrounds.

In general, the review shows a significant number of different programs of integrated type. They include components such as HV, individual and group forms, support for early learning and development of parental skills. These programs have their own models and are adapted to the needs of the local communities.

5.3. Access to services in support of secure and safe environments for children's development

5.3.1. Access to health and other public services of undocumented pregnant women and mothers of children up to age three

Overview of the articles

Ten research-based articles have been reviewed in this focal point of advocacy. These articles add to and upgrade the information from the I part of the research, related to undocumented women. The key demographic characteristics of all of the articles are presented in table 6.

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Table 6 Articles in the focal point of advocacy 'Access to health and other public services of undocumented pregnant women and mothers of children up to age three'

No	Author/s & year of publication	Publication details and link to abstract or full text (if available)	Country/state of study and/ or program implementation
1	Dos Santos, S. L. S. (2015)	Undeserving mothers? Shifting rationalities in the maternal healthcare of undocumented Nicaraguan migrants in Costa Rica. *Anthropology & medicine*, *22*(2), 191-201, https://www.tandfonline.com/doi/abs/10.1080/13648470.2015.1004503 (abstract)	Costa Rica
2	Finnerty, F., George, S., & Eziefula, A. C. (2018)	The health of recent migrants from resource-poor countries. *Medicine*, *46*(1), 66-71, https://www.sciencedirect.com/science/article/abs/pii/S1357303917302712 (abstract)	UK
3	Leppälä, S., Lamminpää, R., Gissler, M., & Vehviläinen-Julkunen, K. (2020)	Humanitarian migrant women's experiences of maternity care in Nordic countries: A systematic integrative review of qualitative research. *Midwifery*, *80*, 102572, https://pubmed.ncbi.nlm.nih.gov/31739182/ (abstract)	Nordic countries
4	Manby, B. (2020).	The Sustainable Development Goals and 'legal identity for all': 'First, do no harm'. World development 139 (2021) https://doi.org/10.1016/j.worlddev.2020.105343 (abstract)	African context
5	Phillimore, J. (2016)	Migrant maternity in an era of superdiversity: new migrants' access to, and experience of, antenatal care in the West Midlands, UK. *Social Science & Medicine*, *148*, 152-159, https://pubmed.ncbi.nlm.nih.gov/26705910/ (abstract)	UK
6	Vanessa, G., Cynthia, M., Chiara, Q., & Nina, S. (2019)	Temporalities of emergency: Migrant pregnancy and healthcare networks in Southern European borderlands. Social science & medicine, 222, 11-19, https://www.sciencedirect.com/science/article/pii/S0277953618307056 (full text)	Spain, Italy, Greece
7	Vanthuyne, K., Meloni, F., Ruiz-Casares, M., Rousseau, C., & Ricard-Guay, A. (2013)	Health workers' perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or a privilege? *Social science & medicine*, *93*, 78-85, https://www.researchgate.net/publication/254263394_Health_workers'_perceptions_of_access_to_care_for_children_and_pregnant_women_with_precarious_immigration_status_Health_as_a_right_or_a_privilege (full text)	Canada
8	Wanwong, Y., Nipaporn, S. , Nopparattayaporn, P., Poungkanta,	Health Insurance for Undocumented Migrants: A Literature Review in Developed Countries, Special Article, J Med Assoc Thai Vol. 100 No. 6 , https://www.researchgate.net/publication/318265024_Health_insurance_for_undocumented_migrants_A_literature_review_in_developed_countries (full text)	Thailand

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	W., Putthasri, W., Suphanchaimat, R. (2017)		
9	Wendland, A., Ehmsen, B. K., Lenskjold, V., Astrup, B. S., Mohr, M., Williams, C. J., & Cowan, S. A. (2016)	Undocumented migrant women in Denmark have inadequate access to pregnancy screening and have a higher prevalence Hepatitis B virus infection compared to documented migrants in Denmark: a prevalence study. *BMC Public Health*, *16*(1), 426, https://www.researchgate.net/publication/303469469_Undocumented_migrant_women_in_Denmark_have_inadequate_access_to_pregnancy_screening_and_have_a_higher_prevalence_Hepatitis_B_virus_infection_compared_to_documented_migrants_in_Denmark_A_prevalence_stu (full text)	Denmark
10	Wolff, H., Stalder, H., Epiney, M., Walder, A., Irion, O., & Morabia, A. (2005)	Health care and illegality: a survey of undocumented pregnant immigrants in Geneva. Social science & medicine, 60(9), 2149-2154, https://www.sciencedirect.com/science/article/abs/pii/S027795360500002X (abstract)	Switzerland

The main demographic characteristics of the articles include **country (countries), in which the program is implemented, target group(s), year of the study, who conducted the study**. Countries where the studies were based are as follows: Denmark; Switzerland; UK; Costa Rica; Italy, Spain, Greece; Canada; Nordic countries, Thailand. The article of Manby (2020) focuses on the African context. Years of the studies are specified in most of the articles.

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Most of the research studies were conducted by academic researchers from universities or a mixed teams of researchers from both university and European program. The article of Wanwong et al. (2017) represent the Ministry of Public Health, National Health Security Office, and two hospitals in Thailand. In addition to the above peer-reviewed articles several other grey sources have been analysed in order to provide more focused information about available measures/ programs/ policies to ensure access to healthcare for undocumented pregnant women and mothers of children up to age three.

Ensuring universal and equitable access to affordable, acceptable, and quality maternal health care throughout pregnancy - including ANC, emergency obstetric care, and skilled birth attendance - is imperative if EU member states are to protect women's health and lives, comply with international public health guidelines, discharge their international human rights obligations, and reduce health system costs.

The interest in the topic, related to UM women and children, seems to have been growing during the last years. Generally, the studies cover the period of 2002 to 2020, most of them related to the recent immigrant situation.

Target groups of the most of research are migrant women. However, undocumented pregnant women comprised an explicit target group of two studies (I.e. Wenland, 2016; Wolff, 2005). Four articles focused on undocumented pregnant women and mothers along with the broader categories of recent migrants from resource poor countries; humanitarian migrant women in Nordic countries; all categories of migrant women (in terms of superdiversity) (I.e. Finnerty et al. 2018; Leppäläet al., 2020; Phillimore, 2016; Vanthuyne et al, 2013). Two articles were based on studies where the participants comprised of practitioners, including physicians and nurses, who provided care to migrant women, both pregnant and mothers (Dos santos, 2015; Vanthuyne et al, 2013). One article had a broader focus on both migrant women and practitioners (Vanessa et al, 2019). The study of Manby (2020) focuses on the 'legal identity for all' according to the Sustainable development Goals of the UN, including UMs in general. The article of Wanwong et

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al. (2017) stresses the health insurance for UMs as a whole, among them pregnant women and children.

Main identified problems and purposes of the articles

Notably, analysed studies focused on **two types of problems** regarding access to health services for UM pregnant women and mothers of children up to three years of age: first, these are problems associated with **objective, external barriers** to providing access to maternity care, and secondly, these are problems experienced at **subjective level**, both by UM women and health practitioners themselves. The two type of problems are interrelated requiring complex solutions. Thus, in summary, the **main problems** discussed in all articles concern access to health care provided to UM women, who are pregnant or have delivered birth to a child while on the move. There are various focuses and discourses of this discussion. Specifically, articles focused on **access to care during pregnancy** of UM women; **access to maternity care** of all migrants, including undocumented pregnant women, mothers and children; **general healthcare problems** of migrant women; **ethical and professional dilemmas** confronting practitioners who deal with maternity care of UM women and children; and **health insurance** for cross-border migrants. In addition, the article of Manby (2020) draws attention to the introduction of 'new 'foundational' national identification systems for adults', including migrants and refugees, and raises some concerns in this respect.

More specifically, the evidence shows that UM women, both pregnant and delivering, face serious problems in relation to **access** to antenatal, perinatal, and postpartum care, as well as regarding the **quality** of such care. One important dimension relates to **policy and legal barriers**, leading to limited access to healthcare for all UM. In UK, for example, undocumented women and failed asylum seekers did not have access to ANC (Philimore, 2016, p. 153). In Denmark, undocumented pregnant women do not have the right to apply for a civil registration number and therefore they do not have access to the Danish screening pregnancy program for human immunodeficiency virus (HIV), Hepatitis B (HBV) and syphilis (Wendland et al., 2016). Finnerty et al. (2017) provide data showing that, in the UK, 17% of migrant people living with HIV are

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unaware of their infection. It is estimated that, if untreated, the risk of mother-to-child transmission of HIV during pregnancy, delivery or breastfeeding is 20–25 %, while HBV infection of babies is associated with prematurity and lower birthweight, and 90 % of new-borns infected with HBV develop chronic hepatitis if no vaccination is administered at birth (ibid, p. 2). Illegal status, including the fear of being caught by the police and poor living conditions, lack of insurance and low income increase maternal and new-born morbidity (Wolff et al. 2005, p. 2150). Phillimore (2016, p. 153) quoted evidence suggesting that **maternal mortality and morbidity** are increased for migrants, particularly those from Africa and asylum seekers, and that across the EU minority and migrant women **tend to book later and use antenatal services less than non-migrant women**. It is noted that entitlement checks and charging present a barrier to vulnerable pregnant migrant women accessing early pregnancy care, leaving them at **risk of complications** (Finnerty et al., 2017). Among other barriers that contribute are **structural inequalities, lack of language competency and poor communication** between non-English speaking migrants and health providers, migration histories or discrimination, constrained material circumstances, lack of understanding of health and maternity systems in the host country (Phillimore, 2016, p. 153-154), lack of awareness of their right to free care (Finnerty et al, 2017), etc.

There is evidence showing that when legal and political barriers do not exist and undocumented pregnant women are entitled to care, **other maternity care** specifics could be observed. In Spain, Italy, and Greece as the borderlands of Europe facing the greatest migrant challenges in the last several years, there are **special laws that allow access to care** for specific categories of UM. Childbirth in the above countries qualify as urgent care under specific clauses but these protective policies and the '**nominal access to care does not do away with sociocultural and other barriers**' (Vanessa et al., 2019, p. 12). It is noted that 'the lived experience of maternity patients, especially undocumented ones, illustrates the treacherously multifarious fragmentations of medical care into the everyday of distant, under-resourced borderlands' (ibid, p. 12).

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In addition, evidence suggest that undocumented women seeking maternal care constitute a **challenge to healthcare systems** in the host countries **in terms of the universal rights to care and perceptions of the so called 'deservingness' of such care** (Dos Santos, 2015; Vanthuyne et al., 2013). Research related to provision of care for uninsured patients 'all concluded that this process is especially conflicted given that it always involves particular moral worlds' (Vanthuyne et al., 2013, p. 79).

Even when governments of the welfare states such as the Nordic countries provide **affordable and good quality of maternal care**, the evidence shows that optimal maternal health remains **unreachable or insufficient for some groups of women** (Leppälä et al., 2020, p. 2). Research data demonstrate various problems related to care for migrant women, such as a significantly higher risk for maternal morbidity and mortality compared to the country-born population in Western high-income settings; significant risks for maternal morbidity in humanitarian migrants, for example, a higher proportion iron deficiency anaemia, gestational diabetes mellitus, over-wight, tuberculosis, HBV and hepatitis C, syphilis, vitamin D deficiency and high blood pressure during pregnancy; less antenatal check-ups, and prenatal screenings; suboptimal perinatal care; increased risk for excessive bleeding, infections, post-partum depression, and avoidable maternal death after delivery (ibid, p. 2), among the others. As noted by the authors, there is 'a solid evidence that **humanitarian migrant women's poorer maternal health outcomes are an unarguable statistical fact**' (ibid, p. 2).

The interesting review article of Wanwong et al. (2017) draws on the policies and practices in providing **health insurance** for UMs, including women and children, in several countries (I.e. UK, Germany, Italy, France, Japan, and the U.S) to address the **illegality problems in public health** in Thailand. Wanwong et al. (2017) describe the efforts of the Thai government to address the issues of access to care for illegal migrants, which include 'endorsing the One Stop Service (OSS) policy, aiming at registering 'all' illegal or undocumented migrants and dependents in Thailand' (p.2.). People who undertake the OSS will be issued the work permit and legitimate residence permit, and will be insured for their health (ibid, p. 2). The health insurance for the registered

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migrants is called the 'Health Insurance Card Scheme' (HICS), according to which 'the insured migrants are required to buy the insurance card with a premium of 1,600 Baht for adult (plus 500 Baht for annual health check) and 365 Baht for a child less than 7 years for a one-year coverage' (ibid, p. 2). Most of the card revenue is pooled at the registered hospital, while a small portion of the revenue is pooled at the Ministry of Public Health (MOPH) to reimburse the expense of advanced treatment (or high cost care) and antiretroviral drugs for HIV/AIDS patients (ibid, p. 2). The benefit package of the card is comprehensive and comprises a wide range of treatments, including outpatient care, inpatient care, specialized treatment, disease prevention, and health promotion (ibid, p. 2). However, '**the problems include the following** 1) there are numbers of illegal migrants who failed to take part in the OSS registration and did not return to their home country, 2) certain hospitals are reluctant to sell the insurance card for migrants due to fear of having small volume of registered migrants that cannot meet the hospital's cost recovery, and 3) there are confusions in policy implementation and varying interpretations of laws, such as whether the unregistered migrant is eligible to buy the insurance card. There was a proposal to the MOPH that there should be **a safety net system** that covered any patient regardless of his/her immigration/citizenship status, who are suffering from emergency condition and catastrophic illness without creating much additional financial burden on the facilities' (ibid, p.2).

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Figure 7 Main problems, targeted in the articles

Directly related to the main problems are the **study purposes**. According to the **purposes of studies**, they could be specified in several ways. Problematizing the access to pregnancy screening program for HIV, hepatitis and syphilis of UM women in Denmark, the study of Wendland et al. (2016) aims to **assess screening frequency in UM women and to compare prevalence of infection in UM with documented migrants (DM)**. The study was implemented August 2011 - August 2014 in three clinics in **Denmark** – two in Copenhagen and one in Jutland. The specific context of the problem is that, in Denmark, 'DM have access to this screening but UM do not, instead relying on ad-hoc care from clinics run by non-governmental organisations' (ibid, p. 1).

Wolff et al. (2005) concentrate on the **description of the socio demographic and health status of pregnant, UM women** in **Geneva** in order to focus future research on the main health problems they experience. Based on the 'striking scarcity of direct evidence' and controversial results of previous studies regarding how the lack of health insurance, illegal status and low

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income increase maternal and newborn morbidity, their study was conducted between October 2002 - October 2003 in the Woman's Hospital.

The article of Finnerty et al. (2017) has no explicitly stated purpose but is directed to **reveal the specifics of the access to healthcare** by recent migrants in **UK**, including UMs, who are entitled to limited National Health System care and are often denied access to all healthcare because of misunderstanding and prejudice.

Sara Leon Spesny Dos Santos (2015) studied the **discourses and perceptions** of health professionals who encounter the UM women that seek care at the **Costa Rican National Hospital** and focused on how these discourses reflect 'some new mechanisms of exclusion' among health providers, 'making it possible to trace different rationalities regarding deservingness of maternal healthcare' (Dos Santos, 2015, p. 192). The study was conducted in 2011 – 2012 year.

The same moral issue of 'deservingness' as the flip side of rights was explored by Vanthuyne et al. (2013, p. 79), whose study in **Montreal** in 2010 aimed **to assess how clinicians, administrators, and support staff contend with the ethical and professional dilemmas** raised by the issue of access to healthcare services for pregnant women and children who are partially or completely uninsured.

The restrictive policies regarding access to secondary healthcare for irregular migrants and failed asylum seekers cause problems experienced by migrant women (Phillimore, 2016). In her article, the author **explores the reasons why new migrant women book late and do not attend antenatal follow-up appointments** and identifies a combination of legal, structural, and institutional barriers (ibid, p. 153). The study was carried out in 2010 in **West Midlands, UK**.

Vanessa et al. (2019) examined the maternity care of migrant patients in state and non-state structures in the **Southern European borderlands (Spain, Italy, and Greece)** within a project frame. The authors' objectives were to **understand changes and continuities in the provision of maternity care to migrants before and after the so called 'refugee crisis'**. Thus, they 'investigate whether and how the understanding or the labeling of the maternity care of migrants as an

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emergency within a context of professed crisis generates new norms of care within health-care delivery' (ibid, p. 12). The study was done in 2016 and 2017 years.

The article of Leppälä et al. (2020) presents a **synthesis of studies on the lived experiences of maternity care of humanitarian migrant women in the Nordic countries.** The systematic review of qualitative research on the above matters seek to answer two research questions: 1 What kinds of qualitative approaches have research studies used in exploring humanitarian migrant women's experiences of maternity care? 2 What hindrances for optimal maternity care do these studies report as described in humanitarian migrant women's lived experiences? (ibid, p. 2).

Wanwong et al. (2017) made their narrative review **with the aim to provide** the current Thai government with 'a knowledge grounds for the development of the health insurance system for cross-border migrants in Thailand (illegal or UMs) (p. 2). Regarding the creation of a safety net system, they found it 'imperative to draw lessons from other countries about to what extent they manage health insurance for cross-border migrants, especially the safety net system for undocumented ones' (ibid, p. 2).

Finally, the article of Manby (2017) 'argues that the introduction of new 'foundational' national identification systems for adults and more pervasive requirements for proof of identity, without simultaneously addressing gaps in the legal framework governing the determination of legal status, risks making the problems around proof of legal identity worse rather than better'(p. 1) and 'reemphasises the importance of the discussions of **legal identity**, which now increasingly take the form of discussions of ***digital identity***, for scholars of world development' by doing so 'with particular reference to the challenges of 'providing legal identity' in Africa' (p. 2).

The analysed articles study access to and quality of healthcare services for undocumented pregnant women and mothers of children up to age three within the broader context of policies and practices concerning the right to health for all. Specific problems, related to both structural barriers and personal experiences, are largely discussed. In some of the articles, the focus is put on national policies and international initiatives to 'leave no one behind', such as policy

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approaches regarding access to care for UMs regardless of the legal status and the UN initiative for introducing digital identification system.

Problem solutions

There are various **solutions** proposed to the identified problems under study. First, the issue of **equal and equitable access** to healthcare for all migrants regardless of their political or migrant status is put forward (Vanessa et al., 2019; Vanthuyne et al., 2013, Wanwong et al., 2017). Vanthuyne et al. (2013, p. 84) argued that universal access to healthcare for immigrants with precarious status should be reconsidered as constituting **a right, not a privilege,** and misconceptions about the nature of precarious status migrants' 'illegality', their socioeconomic circumstances, and their contributions to the host society should be challenged.

To ensure good health and favourable outcomes for the new-borns, **safe and accessible services for screening of pregnant UM are needed** (Wendland et al., 2016). It is argued that providing free and systematic access to pregnancy screening is in line with international treaties, including pre and PNC and right to health for children of UMs (Wendland et al., 2016).

There is a call for **innovative approaches** to reduce the significant inequalities in health of migrants (Finerty et al., 2017; Philimore, 2016). **Increasing familiarity with the new recommendations** applied in the UK (Finerty et all, 2017); providing **training in intercultural competence** to health professionals in maternity services as 'an important foundation for professionals and migrant women to begin to build the health cultural capital necessary to ensure effective antenatal interactions' (Philimore, 2016, p. 158).

To find solution to the problem addressed by Wanwong et al. (2017), namely that a due number of migrants in Thailand failed to register with the government agency, and were uninsured by the available scheme (p. 8), the authors made a narrative review and draw on **several policy approaches** explored in developed countries that try to ensure access to healthcare for UMs on their territories. The findings are described in the respective section below.

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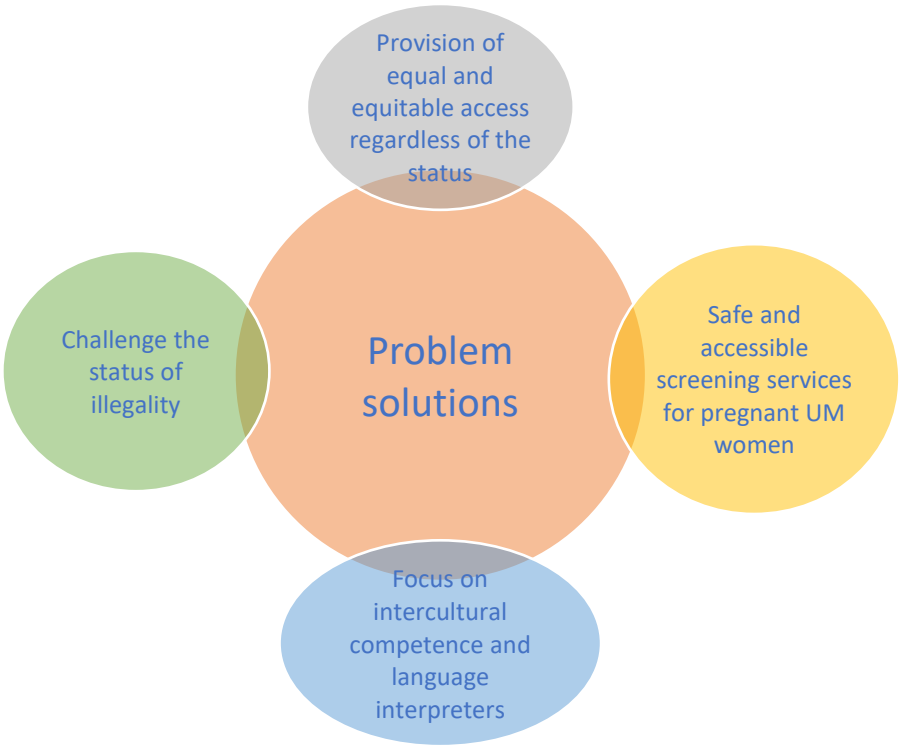
Figure 8 Problem solutions



Conceptual framework

Importantly, studies are informed by the concepts of humanity, social justice, equality and equity of access to basic human rights, empowerment, etc. The study of Dos Santos (2015, p. 92) explores the conceptual framework of **access to health care** as the lens through which the paper 'looks at how reproductive health is shaped by citizenship status'. Vanessa et al. (2019) use an anthropological approach as a theoretical as well as empirical perspective on the pluralism of responses to situations of **urgent need** that 'calls for a combined attention to a) the structural factors and processes of violence, inequality, and the exercise of power and b) the ways people grapple with moral dilemmas, display empathy, and conceptualize and try to do good within the context of their socio-cultural meanings and relation' (ibid, p 12). Philimore (2016, p. 154) mentioned the concept of the **health cultural capital** that may help 'to understand the way that inadequate repertoires of cultural skills, communication competencies and interactional styles on the part of patients and professionals contribute to unequal treatment and outcomes'. The

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conceptual framework of **social justice** was explored by Leppälä et al. (2020) in carrying out their systematic review. They argued that social justice as the moral foundation for public health recognizes that 'in a just world, all women should have the same possibility for health in terms of pregnancy and childbirth' (ibid, p. 2).

Study design and methodology. Findings

Two of the studies use **quantitative approach** to collect and process data. To study the screening frequency of undocumented women and to compare the prevalence of infections in UM and documented ones, Wendland et al. (2016) obtained individual-level information on HBV, HIV and syphilis testing frequency and results for pregnant women who attend three clinics specializing in care for UM. They accessed aggregate data on the prevalence of the three infections for documented migrants from the Danish pregnancy screening program and birth register (2011-2014), described demographic features of pregnant UM and estimated the screening frequency for HIV, HBV, and syphilis. Finally, they compared prevalence of current infections in UM and documented migrants (DMs) by calculating standardized prevalence ratios (ibid, p. 1).

Wolff et al. (2005) carried out a study through **a questionnaire** delivered to the participants by a midwife who did the follow ups at the Woman's hospital. The questionnaire contained 19 questions aimed to reveal information about socio-demographic characteristics and an open question about the major difficulties of life. SPSS for Windows was used for data analysis. Means for continuous variables or proportions for categorical variables were compared by applying standard statistical tests.

An online questionnaire consisted of 18 Likert-type or multiple-choice questions, plus one open-ended question was used by Vanthuyne et al. (2013) to examine the health workers' perceptions of access to care for children and pregnant women with precarious immigration status. All practitioners (e.g. physicians, nurses, and social workers), administrators, researchers, and other support staff, based in 3 hospitals and 2 primary care centres in Montreal (n=1048) were included in the study. However, the article explores qualitative data based on comments provided by 237 respondents (23% of all survey respondents) who provided detailed comments in the open ended

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space at the conclusion of the survey or for one of three questions offering 'other' as a response choice (ibid, p. 80).

The other studies used **qualitative and mixed method research** to examine their subjects. Dos Santos (2015) explored the **in-depth interview** with high-level authorities, third parties, health providers both physicians and nurses, and hospital administration personnel at a Costa Rican National Hospital. The methodology was complemented by **observation** of approximately 48 hours in the local hospital and informal visits to existing primary care facilities (or Basic teams for comprehensive health care) (ibid, p. 193). The analysis was based on 10 recorded in-depth interviews.

The **ethnographic study** of Vanessa et al. (2019) was based on **fieldwork** and used **interviews** and **participant observations** in several locations in Italy, Greece, and Spain: Lampedusa and Siracusa in Italy; Athens, Greece; and the autonomous Spanish enclave of Melilla in Northern Africa, on the border with Morocco. The study sites included the spaces where the participants – 'migrant women positioned along the documented-undocumented continuum – resided and received medical care: the premises of health centers, public hospitals, and medical NGOs; and refugee camps and accommodation centers, hotels, apartments, and urban squats' (ibid, p. 13). The methodology further included long-term participant observation with migrant women and health-care professionals in the public and NGO sectors including health-care assistants, nurses, midwives, and gynecologists; and also volunteers, social workers, bureaucrats, and local authorities (ibid. p. 13).

The research of Phillimore (2016) used a **triangulation methodology** that combines a semi-structured questionnaire with migrant women, 13 in-depth interviews with migrant women, and 18 in-depth interviews with maternity professionals including community health staff; GPs; pregnancy outreach workers; hospital staff; and third sector workers (Phillimore, 2016, p. 154-155).

Finally, the systematic review of Leppälä et al. (2020) presented **inductive thematic analysis** of 10 articles containing qualitative research on humanitarian migrant women's experiences of

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maternity care in Nordic countries. The articles were selected through electronic search in PubMed, CINAHL, SocIndex, Scopus, PsycINFO and Web of Science based on PICoS inclusion and exclusion criteria. Critical appraisal was conducted utilising 32-item COREQ tool (ibid. p. 3).

The article of Wanwong et al. (2017) represents a **narrative review** of literature searched in the database of the 'Platform for International Cooperation on Undocumented Migrants (PICUM)', which explored policy approaches regarding access to care for UMs for the EU member states, and sources of literature outside the EU, such as the Asia Pacific Journal and official websites of the authorities accounting for health care management for Ums in certain countries such as Japan and the U.S .(p. 8). In the study limitations part, the authors mentioned that 'the review did not screen for quality of evidence and the review protocol here was less stringent and less comprehensive than the systematic review' (ibid, p. 8).

The article of Manby (2020) is published in World Development, which is a multi-disciplinary monthly journal of **development studies**, presenting constructive ideas and analysis, and highlighting the lessons to be learned from the experiences of different nations, societies, and economies[31]. The current article builds on arguments made by another author Simon Szreter in World Development in 2007 regarding 'the right to have one's legal identity and relationship to significant others publicly recognized, securely registered, and accessible for personal use', and analyze one of the UN SDG, namely that the states should, by 2030, 'provide legal identity for all, including birth registration' (p. 1).

Studies differ in design and methodological approaches applied to the problems under investigation. They could be grouped into the two common categories of primarily quantitative and primarily qualitative research, although some of them are based on mixed methods approach. It is of notice that most of the articles under analysis explored either qualitative or mixed methods framework, which could be explained by the purpose and the necessity to provide an in-depth understanding of the migration-related phenomena.

[31] See https://www.journals.elsevier.com/world-development)

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There are **various findings** showing that access to care for undocumented pregnant women is shaped by serious **structural, institutional, and moral issues**. Several important **common findings** were reported. They concern late presentation to screening for infectious diseases (Wendland et al. 2016); late booking or registration of pregnancy for ANC (Philimore, 2016); high prevalence of unintended pregnancies and abortions (Vanessa et al., 2019; Wendland et al. 2016; Wolff et al., 2005); lower access to pregnancy screening (Wendland et al. 2016; Wolff et al., 2005); higher prevalence of HBV infections (Finnerty et al., 2017; Wendland et al. 2016) and more.

Specifically, Wendland et al. (2016) **found** that over half of the women visited the clinic for the first time after week 10 of their pregnancy; a large proportion (50–71 %) of women attending the two sex worker clinics requested an abortion, suggesting a high level of unplanned pregnancies; only 60 % of women eligible for screening had a HIV test result recorded, compared to 99.9 % of the Danish legal residents; the lowest percentage of recorded screening results for HBV: overall, only 43 % of pregnant UM had a screening result recorded, compared to 99.9 % of pregnant women with legal residency in Denmark. 58 % of UM women had a recorded screening result, compared to 99.7 % in pregnant women with documented residence in Denmark (ibid, p. 6-8).

Wolff et al. (2005, p. 2153) **reported** that four out of five pregnancies resulting in live births were unintended and that the Centre of birth control gives estimates of nine out of 10 pregnancies of undocumented immigrants being unintended and 60% of the pregnancies leading to abortion. The study also confirms that cervical cancer screening for undocumented Latinas was underutilized, as only 44% had a Pap test within the last 3 years, 31% had never had one in their life (ibid, p. 2153). They concluded that the low socio-economic status and the lack of social or legal protection of undocumented Latina women in Geneva lead to the prevalence of sexual, physical and emotional abuse; undocumented immigrants lack access to important preventive measures, with the main health issues were unintended pregnancies, insufficient rubella immunization and lack of cervical cancer screening (ibid, p. 2153).

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The field research of Vanessa et al. (2019) provides a detailed analysis of the specific experience of pregnancies of UM women. Research participants in their study became pregnant within the condition of the migration. Generally, pregnancies were often unplanned and had occurred on the trail in Italy; 'because of the high rate of violence suffered along the Central Mediterranean route, pregnancies were often unplanned and had occurred on the trail, mostly in Libya. Consequently, health professionals were faced with a high number of abortion requests' (ibid, p. 14). Migrants in Greece are found to be less vulnerable to sexual and gender based violence in Greece; the experience of being pregnant while on the move is an expected element of their lives, ensuring the continuity of their family lives in spite of other hardships that characterized their trajectories in Spain (ibid, p. 14). It was concluded that pregnancies largely followed migrants' premigration plans (ibid, p. 15). Generally, **the findings** of Vanessa et al. (2019) suggest 'a) the adoption of solutions or practices that in the past might have been considered urgent, ad hoc, or creative; b) their normalization, deeply connected to the wider social landscape of these European peripheries and c) the institutionalization of humanitarianism in the context of these practices' (ibid, p. 11). They also found that 'in the context of austerity-driven underfunding, **temporary solutions** become entrenched, producing a lasting emergency' and this 'emergency' can, at some point, generate practices of resistance that undermine its 'own normalization' (ibid, p. 11).

Studies and especially qualitative research dealt with a thorough exploration of reasons behind particular behaviours of undocumented pregnant women. For example, Phillimore (2016, p. 156) **found** that, in West Midlands, they book late 'for a range of reasons including not having sufficient information about services (8), not understanding the services available (5), lack of translated materials (4) lack of an interpreter (4) or not being registered with a GP (2)'. Women with immigration problems worried about being tracked by immigration authorities and their babies removed if they registered with maternity services (ibid, p. 156). Furthermore, the study **found** 'no evidence that migrant women undervalued ANC or that late attendance was a problem experienced within particular ethnic groups but instead was influenced by a range of legal, structural and institutional barriers'(ibid, p. 157). Structural barriers such as socio-economic

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conditions, language barriers, as well as institutional barriers in terms of the institutional culture of the maternity services designed for those who understand and can negotiate the systems were among **the main findings.** The author also found that **migrant status and not solely ethnicity** is perhaps the key factor increasing the vulnerability of migrants and is associated with structural and institutional barriers to attending ANCor receiving efficacious care (ibid, p. 158).

The review article of Leppälä et al. (2020) **revealed three major themes** emergent from the inductive analysis of the qualitative research on humanitarian migrants' experience of maternity care: **a diminished negotiation of power; sense of insecurity; and experienced care-related discrimination**. The study **found** that the diminished negotiation of power related to humanitarian migrant women's pre-existing gaps in heath literacy; late, lacking and incongruent provision of health information in the current country of residence, and diminishment or unrecognition of care needs by care professionals (ibid, p. 8). Their sense of insecurity builds on the limited ability to convey their needs, fear of negative consequences if seeking care, and general suspicion and mistrust towards authorities (ibid, p. 10). Experienced care-related discrimination consisted of complicated, questioned or denied access to care, and care professionals' negative attitudes and behaviour towards humanitarian migrant women (ibid, p. 10).

Attitudes and behaviours of the many actors involved in the healthcare for UM women and children were thoroughly explored by Vanthuyne et al. (2013) and Dos Santos (2015). Vanthuyne et al. (2013, p. 80) **found a wide gap among health care workers**, between attitudes towards entitlement to universal healthcare access, and the endorsement of principles stemming from human rights and the best interest of the child. They also **found** that variables such as country of origin, institutional affiliation and profession impact these attitudes (ibid, p. 80). Among the arguments against the universal access to healthcare were those that 'illegals' without coverage are unworthy of care unless their diseases constitute a threat to the public health and that universal access to healthcare in Quebec or Canada had the effect of attracting unwarranted numbers of 'clandestine migrants' (ibid., p. 81). Arguments in favour of universal access to

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healthcare revealed a combination of 'health ethics' and 'preventive fiscal' frameworks points of view (ibid. p. 81). Thus, medical care was perceived as a fundamental human right and children with precarious immigration status were viewed as the most helpless and therefore the most deserving of healthcare services (ibid. p. 81). About one third of respondents supported both positions (ibid. p. 82).

In the UK maternity care is regarded as secondary care where UMs are liable to pay the treatment expense. Some of the NHS were not recognized the rights of UMs. the NHS attempted to resolve these confusions by establishing a hotline service where health care staff can contact in order to check for the rights of each individual patient.

Dos Santos (2015) explored the theme of deservingness of care for undocumented Nicaraguan pregnant women and identified **several important findings**. First, she **found a malleability of concepts** of universality, solidarity, and equality in Costa Rican language: 'Universality finds room for exclusion, solidarity has shifted towards the system - not the population - and equality refers to the quality of treatment, not access to services' (ibid, p. 193). Secondly, restrictions on prenatal care instigate women to engage in individual negotiations mediating their admission to emergency services through their bodies; so, **embodiment during pregnancy is then a determining factor of treatment** (ibid, p. 194). Thirdly, in the Catholic state like Costa Rica, the figure of the pregnant woman represents a moral dilemma for health providers because even if they express ambiguity towards a woman's deservingness, the life of the foetus determines the imperative of treatment (ibid, p. 195). Undocumented pregnant women are perceived as marginal women and moral and legal trespassers; 'while the woman is guilty, the foetus is innocent; while one deserves treatment and care, the other merits control and surveillance' (ibid, p. 195). Finally, the discourses revealed in this study were summarized by the author as 'rationalized ambivalence' reflecting 'the imperative of deservingness for an a priori undeserving population' and serving 'both to explain

In Italy UMs are eligible to acquire 'Temporary Residing Foreigner Code', with a 6-month validity. This will serve as a health card guaranteeing the rights to enjoy a variety of essential services. Normally, this includes treatment for infectious diseases, HIV/AIDS, TB, occupational injuries, and maternal and childcare.

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and justify exclusion' (ibid, p. 196). This subjective ambivalence is related to a structural ambivalence (ibid, p. 197).

On the basis of the narrative analysis of the policy approaches and health insurance systems in several developed countries (namely, UK, Germany, Italy, France, Japan and USA), **the findings** of Wanwong et al. (2017) shows that the level of care provided to UMs can be categorized into **four levels:** 'The first level is the health insurance for legal migrants with legitimate residence permit. In this level, legal migrants are eligible to utilize services almost at the same degree as the native citizens; The second level is the insurance for previously illegal migrants who underwent the registration with the authorities. The degree of care for this level varies between countries. Normally, the registered patients are able to utilize emergency services and primary care with free of charge or minimal charge; The third level is the population- or disease-specific insurance for certain population groups, such as pregnant women and children, or persons with communicable diseases; The fourth level is the special funding program that aims to recoup the treatment cost that the facilities shouldered from catering care for the uninsured populations. Only Japan and France implemented this system; while Japan focuses on tertiary

The California's local government has established the city's insurance project for UMs, namely, the restricted Medi-Cal. In order to be entitled to the scheme, the applicants must provide a proof of residence to the officials, such as expired VISA or LA residence card. The basic benefit package include, among all, maternity and child care (family planning, ANC, delivery care, and post-natal care up to 60 days) and beneficiaries can use it free of charge (in Wanwong et al., 2017, p. 3-6).

In Germany the rights to care of UMs are limited to certain services, such as PNC and care for infectious diseases. For such services, there will be no charge incurred by an UM patient if he/she applies for the Health Card (Krankenschein) with the Welfare Office. The state will then issue a Toleration Certificate, so-called 'Duldung', which warrants the rights to care of a patient, while he/she is under a temporary suspension of expulsion. In some local regulations, the coverage of the Duldung expands to pregnant women (6 weeks before delivery and 8 to 12 weeks after delivery and children) as well.

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In Japan there were some attempts to endorse the laws that provide safety net to UMs, some prefectures allow UM patients to apply for the No-Visa Holder Identification Card, giving the card holders rights to utilize inpatient care in certain clinics/hospitals. The Japanese health system also provides pregnant women and their newborns rights to maternity care regardless of their immigration status according to the Mother and Child Health Law, with the benefit including ANC, PNC and vaccination. The beneficiaries can enjoy such services according to the number of coupons received. These services are equally financed by the central government and the local municipality.

care, the French system is limited only to emergency care. To reimburse from this fund, the facilities need to submit the patient details and extensive information of the patient's treatment to the funding authority, and the reimburse requested will be considered case-by-case' (Wanwong et al., 2017, p. 6-7). Additionally, the authors mentioned that some migrants are ignorant about their benefit (ibid, p. 8).

Recommendations in the articles

There are **several recommendations** made to overcome the problems identifies and examined in the articles. A systematic access to prenatal care is proposed to include all pregnant UM women in routine pregnancy screening programs. This will lead to earlier presentation to health care services and improve screening coverage for preventable infectious diseases to protect the child from vertical transmission with HIV, HBV, and syphilis. Thus, the recommendation of Wendland et al. (2016, p. 9) is to give systematic access to routine pregnancy screening to all UM, integrated into the regular healthcare system, to protect new-born babies from infection with preventable diseases and to address the observed health care inequity. Similarly, support to programs addressing the specific needs of migrant population is recommended by Wolff et al. (2005).

Vanthuyne et al. (2013, p. 84) suggest a need, at the societal and institutional levels, to redress the idea of the healthcare as a right and not a privilege by providing accurate, factual information about the rights of migrants with precarious status, their genuine position in the global marketplace, and the vulnerability of their health, and by creating a safe space for discussions.

Increasing the intercultural competence of practitioners who deal with migrants (Phillimore, 2016) and adopting culturally sensitive approaches when managing stigmatizing diseases

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(Finnerty et al., 2017) are among the recommendations that are directed to optimizing access to, utilization and quality of maternal care for the super diversified new migrants in the UK.

There are very specific recommendations to address the identified problems in maternity experience of humanitarian migrant women, proposed by Leppälä et al. (2020). The recommendations are as follows:

Enable negotiation power by:

- Providing sufficient, timely, and understandable information.
- Acknowledging humanitarian migrant women's vulnerable position but facing the person as a competent adult.
- Ensuring woman's ability to convey needs at all stages of care process, through a professional and trustworthy interpreter in case of language barrier.

Increase the sense of security by:

- Recognizing care professional's' ethical responsibility to provide safe, good-quality, and trustful care-relationship

Prevent care-related discrimination by:

- Improving care providers' cultural competence
- Educating stakeholders on humanitarian migrant's legal position in maternity care (ibid, p. 12).

It must be noted that, generally, there is a paucity of research on effective policies, programs and practices addressing the common healthcare issues of undocumented pregnant women and mothers of children up to age three, at least in this particular focal area of advocacy. As mentioned by Wanwong et al. (2017, p. 8), most academic literature on the health insurance management for migrants focuses on challenges to care experienced by individual migrants and providers without exploring the issue at a policy level.

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So, for the purposes of this report some other resources (the so-called grey literature[32]) were also explored. Specifically, the World Bank Group Identification for Development initiative and the European Network on Statelessness were accessed and analysed to present some evidence in relation to the opportunities to address the major problems of UMs globally, including the right to health and other rights. Generally, the word is going on about providing legal identity and birth registration for all.

Grey literature

In September 2015, the United Nations (UN) General Assembly endorsed the view of the importance of registration and identification for economic development (Manby, 2020). In October 2019, the World bank group issued a Guideline for practitioners under the initiative **ID4D (Identification for development)** to help considering, designing, implementing, or managing a foundational **digital identification (ID) system.** To ensure that everyone has access to identification is the explicit objective of Sustainable Development Goal (SDG) Target 16.9—to 'provide legal identity for all, including birth registration' by 2030. It is mentioned that **identification is also a key enabler or contributor to many other SDG targets**, including unique ID for health insurance — Target 3.8; tracking of TB and HIV/AIDs treatment — Target 3.3; end preventable deaths of newborns via CR health data — Target 3.2; higher childhood vaccination rates — Goal 3 and Target 3.3 and more. As of 2018, the ID4D Global Dataset estimates that there are 1 billion people worldwide who do not have basic identity documents, among them **migrants, refugees, asylum seekers, stateless persons**, and others.

According to the 10 Principles on Identification for Sustainable Development, **Pillar 1. Ensuring universal coverage for individuals from birth to death, free from disrimination**, countries should provide legal identification to **all residents - not only citizens - from birth to death**, including a

[32] **Grey literature** (or **gray literature**) is materials and research produced by organizations outside of the traditional commercial or academic publishing and distribution channels. Common grey literature publication types include reports (annual, research, technical, project, etc.), working papers, government documents, white papers and evaluations. Organizations that produce grey literature include government departments and agencies, civil society or non-governmental organizations, academic centres and departments, and private companies and consultants (Wikipedia).

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commitment to universal birth registration for those born on in their territory or jurisdiction and linking civil registration and ID systems, when appropriate. Additionally, ID systems should be **free from discrimination** in terms of access and use. It involves identifying and mitigating all exisiting barriers to enroll in and use ID systems, with special attention to a large number of vulnerable groups of people, among them **migrants, the forcibly displaced, and stateless persons**.

To introduce the new identification system countries should determine coverage and gaps in the existing systems. It is not without problems, since the states strongly resist infringement on their sovereign discretion to decide these categories and to record them in the new or upgraded identification systems (Manby, 2020, p. 2). The World Bank proposed model for new digital identity systems draws on the **'Aadhaar'** biometric registration and identity number developed in India. Actually, the 'foundational' layer ('aadhaar' means 'foundation') is not linked to legal status in the country: the only criteria for enrolment are residence in India and provision of biometric identifiers (Raghavan et al., 2019) (cited in Manby, 2020). These biometric data include fingerprints and retinal scanning of the eyes. Aadhaar represents a 12-digit individual identification number against which all residents of India can receive social benefits and some administrative services.

Within the UN system, the UN High Commissioner for Refugees (UNHCR) launched a ten-year campaign to end **statelessness** in 2014, the year before the SDGs, and has adopted a series of guidelines and best practices documents interpreting state obligations to end statelessness and respect the right to a nationality (Manby, 2020, p. 9). The various European institutions have issued judgments and guidance protecting the right to a nationality, including a comprehensive recommendation on the nationality of children (ibid, p. 9). In their first thematic briefing on Birth registration and the prevention of statelessness in Europe the European Network on Statelessness pointed out that the lack of birth registration is not the same as statelessness, but heightens the risk of leaving children without a nationality, which in turn cause severe disadvantages accessing rights and services, including school, healthcare and social security,

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whilst also facing an increased risk of exploitation, such as child marriage, trafficking, forced recruitment and child labour[33].

The Statelessness index issued by the European Network on Statelessness provides some good practices for tackling the issues of statelessness and birth registration in 24 European countries. For example, since August 2018, a new law in Greece provides that undocumented mothers about to give birth must be admitted to public hospitals and issued with an ad-hoc ID including their personal information based on a statement, in order to assist with the registration of the child's birth (p. 8). In the area of documentary proof of birth, Bulgaria is among the countries, where all children are issued a birth certificate upon registration, without any further action being required by the child or the parents (p. 10). Regarding existing procedures for establishing whether a child would otherwise be stateless, some countries have provisions in place to ensure that children born to refugees can acquire a nationality. For example, in Belgium, parents who are unable to apply to the diplomatic or consular authorities of their country of origin because they are refugees are exempt from doing so as a prerequisite for their child born in Belgium to acquire Belgian nationality (p. 13).

According to the thematic briefing, in order to ensure that all children have their births registered regardless of their or their parents' residence status, international norms and good practice urge States to prohibit data sharing between health or registration officials and immigration enforcement authorities but only Switzerland prohibits this in law. In Switzerland, an Instruction to the Civil Registry Ordinance on the registration of non-nationals explicitly prohibits public officials from reporting people with irregular residence status to the migration authorities when registering births (p. 15-16). Bulgaria is mentioned among the countries where no mandatory reporting requirements exist but there are instances when health authorities may decide to do so (p. 16). As for the late birth registration, Spain is given as a good example of practice where it

[33] See https://index.statelessness.eu/news/new-index-thematic-briefing-birth-registration-and-prevention-statelessness-europe

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happens. In Spain, even when the deadlines for registration are surpassed, it is possible to file for a late registration so that no birth remains unregistered (p. 17).

The European Network on Statelessness also determines four key areas of urgent action needed to be undertaken by both the European institutions and states to address the remaining barriers to birth registration, prevent statelessness and ensure every child born in Europe acquires a nationality. These are as follows:

1. Access to immediate, free birth registration and certification for all children, regardless of their parents' documentation or residence status, or other aspects of their identity. Among the actions under this key area are to remove barriers to reproductive healthcare preventing women from giving birth in public health facilities and registering the births of their children and to provide accurate, targeted and accessible public information about birth registration procedures.

2. Remove mandatory reporting requirements that deter people from accessing healthcare and/or civil registration. Here, the actions urge that any requirements for public officials to report people with irregular residence status to immigration authorities and monitor practice to ensure this does not happen are removed; introduction of legal safeguards ('firewalls') to prohibit public officials from reporting people to immigration authorities when accessing healthcare or civil registration services; issue of targeted, accessible, public information to inform people about their rights to access healthcare and civil registration services.

3. Improve procedures to determine the child's nationality and identify where they would otherwise be stateless.Under this area, actons are needed to build the capacity of civil registry officials through training and guidance to identify (the risk of) statelessness during birth registration and to ensure that children are treated as nationals for the purposes of accessing their fundamental rights while their nationality is determined as soon as possible and in line with their best interests, among the others.

4. Improve local, national and regional data on birth registration. This area includes actions to improve cooperation between local, national, regional and international institutions to collect

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and publish accurate birth registration data and to increase efforts to gather and publish data on birth registration rates among populations disproportionately facing barriers to registration, including UMs, refugees, members of minority groups, people in residential care, immigration detention or prisons, asylum reception centres, informal settlements, and homeless people (p. 19-20).

It could be summarised that some of those actions address the major problems identified in the articles and especially the removal of barriers to access to health care services under the fear of being reported to the immigration authorities.

5.3.2. Community-based services in support of positive parenting in poor environment

Overview of the articles

Ten research-based articles have been reviewed in this focal point of advocacy. Some of the articles are related to identified practices from the I part of the research. Among them is the Triple P program, as well as a number of other group programs for development of parental skills (in 3 of the articles). The key demographic characteristics of all of the articles in this focal point of advocacy are presented in table 3.

Table 7 Articles in the focal point of advocacy 'Community-based services in support of positive parenting in poor environment'

№	Author/s & year of publication	Publication details and link to abstract or full text (if available)	Country/state of study and/or program implementation
1	Rodrigo, M. J. (2010)	Rodrigo, M. J. (2010), Promoting positive parenting in Europe: New challenges for the European Society for Developmental Psychology. *European Journal of Developmental Psychology*, *7*(3), 281-294. Retrieved from: https://www.tandfonline.com/doi/abs/10.1080/17405621003780200	EU
2	Vázquez Álvarez et al., (2017)	Vázquez Álvarez, N., Molina Garuz, M. C., Ramos, P., & Artazcoz Lazcano, L. (2017). Effectiveness of a parent training program in Spain: Reducing the Southern European evaluation gap. Gaceta Sanitaria, 2017, vol. 33, num. 1, p. 10-16. Retrieved from: https://reader.elsevier.com/reader/sd/pii/S0213911117301711?token=A847A	Spain

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		EA61E22596E9538C1E597D47DE9FF687425A4E8B04D6C8536055F16E1D3FF648BEC0505117895741C56BFBF9243	
3	Durrant et al. (2017)	Durrant, J., Plateau, D. P., Ateah, C. A., Holden, G. W., Barker, L. A., Stewart-Tufescu, A., ... & Ahmed, R. (2017). Parents' views of the relevance of a violence prevention program in high, medium, and low human development contexts. International Journal of Behavioral Development, 41(4), 523-531. Retrieved from: https://journals.sagepub.com/doi/abs/10.1177/0165025416687415 (abstract only)	International
4	Shah et al. (2016)	Shah, R., Kennedy, S., Clark, M. D., Bauer, S. C., & Schwartz, A. (2016). Primary care–based interventions to promote positive parenting behaviors: A meta-analysis. Pediatrics, 137(5). Retrieved from: https://pediatrics.aappublications.org/content/137/5/e20153393	USA
5	Sanders et al. (2003)	Sanders, M. R., Cann, W., & Markie-Dadds, C. (2003). The Triple P-Positive Parenting Programme: a universal population-level approach to the prevention of child abuse. Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect, 12(3), 155-171. Retrieved from: https://onlinelibrary.wiley.com/doi/abs/10.1002/car.798 (abstract only)	Australia
6	Hahlweg et al. (2010)	Hahlweg, K., Heinrichs, N., Kuschel, A., Bertram, H., & Naumann, S. (2010). Long-term outcome of a randomized controlled universal prevention trial through a positive parenting program: is it worth the effort? Child and adolescent psychiatry and mental health, 4(1), 14. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/20470435/ (summary only)	Germany
7	Weaver et al. (2019)	Weaver, N. L., Weaver, T. L., Loux, T., Jupka, K. A., Lew, D., & Sallee, H. (2019). The impact of RISE Up! in promoting positive parenting and safety behaviors of parents with young children. Children and Youth Services Review, 105, 104422. Retrieved from: https://www.researchgate.net/publication/334577919_The_impact_of_RISE_Up_In_promoting_positive_parenting_and_safety_behaviors_of_parents_with_young_children (abstract only)	USA
8	Svendsen et al. (2020)	Svendsen, S., Griffin, J., & Forkey, H. (2020). Using the Attachment Relationship and Positive Parenting Principles to Build Childhood Resilience. Advances in Pediatrics, 67, 15-28.	USA
9	Shan et al. (2019)	Shan, W., Zhang, Y., Zhao, J., Zhang, Y., Cheung, E. F., Chan, R. C., & Jiang, F. (2019). Association between Maltreatment, Positive Parent–Child Interaction, and Psychosocial Well-Being in Young Children. The Journal of pediatrics, 213, 180-186. Retrieved from: https://www.researchgate.net/publication/335078059_Association_between_Maltreatment_Positive_Parent-Child_Interaction_and_Psychosocial_Well-Being_in_Young_Children (abstract only)	China

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10	Hornor et al. (2020)	Hornor, G., Quinones, S. G., Boudreaux, D., Bretl, D., Chapman, E., Chiocca, E. M., ... & Morris, K. A. (2020). Building a Safe and Healthy America: Eliminating Corporal Punishment via Positive Parenting. Journal of Pediatric Health Care, 34(2), 136-144. Retrieved from: https://www.researchgate.net/publication/337892543_Building_a_Safe_and_Healthy_America_Eliminating_Corporal_Punishment_via_Positive_Parenting	USA

The main demographical characteristics of the articles include **country (countries), in which the program is implemented, target group(s), year of the study, who conducted the study**. It should be noted that they are based on research and realised across the whole world: a research in various EU countries, Spain, Germany, USA, a research in various South American and Asian countries, Australia, and China. Therefore, in this area is the biggest scope of scientific articles.

The interest in the topic, related to positive parenting, seems to have been growing during the last two decades, since **the articles are relatively new – published after 2003 - 2020**.

In 2006 'the Committee of Ministers of the Council of Europe launched Recommendation 19 (2006) on 'Policy to Support Positive Parenting' as being of high importance for developmental and educational science, for family and social policy, and society in general' (Rodrigo, 2010).

'In this Recommendation the importance to children of growing up in a positive family environment is endorsed and the responsibility of the state to create the right conditions for positive parenting is emphasized. The Recommendation also intended to encourage parents to seek assistance if they encounter difficulties in bringing up their children as well as to encourage them to eliminate the use of corporal punishment in disciplining children and to acquire alternative methods. The objective of this survey was to identify the different kinds of state support to the family provided in the EU Member States in recent years, focusing in particular on the support given to parents though parental education programmes and counselling' (ibid). This most likely gave impetus to the interest in this topic and development of different programs, respectively, conduction of studies of the results and impact of the implementation of these programs.

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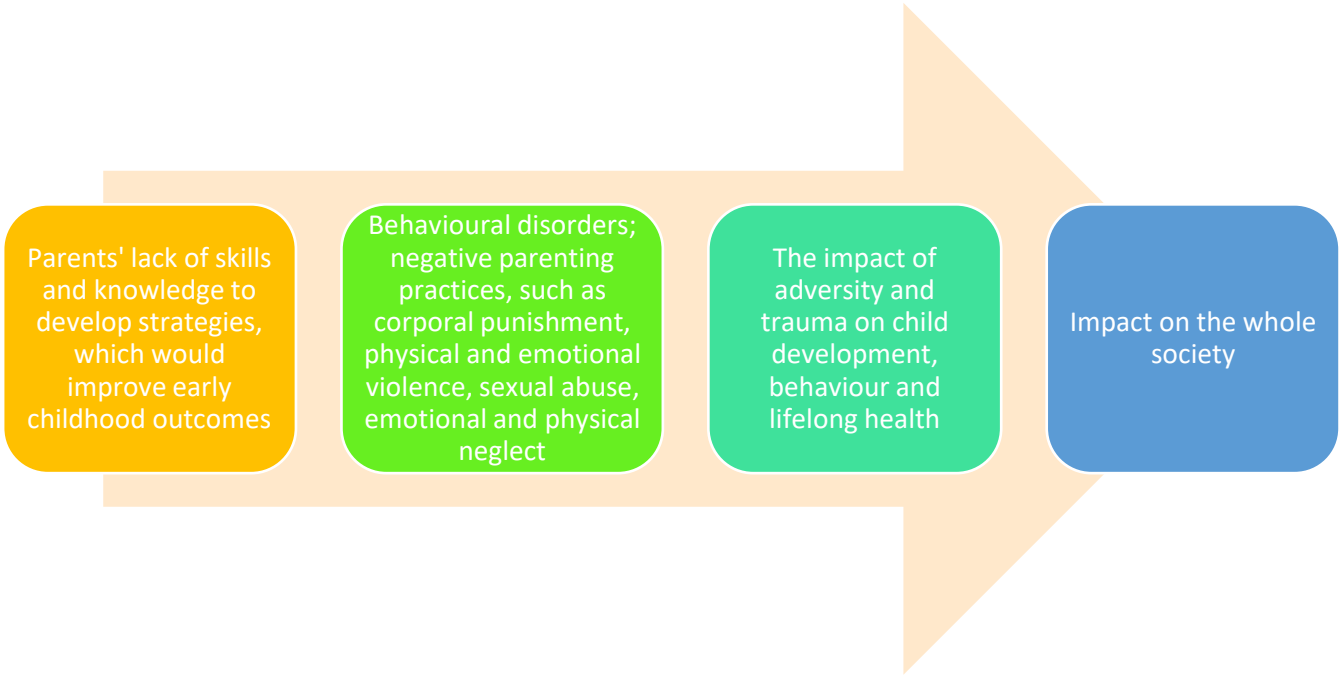
Mostly public entities, such as universities, **have conducted the studies**. Parents and families are **target groups**. These are sometimes children victims of violence, families with children from vulnerable communities, ethnic communities, and groups. Having in mind that most of those programs are related to the development of parenting capacities, focus in research are parents and their behaviour.

Main identified problems and purposes of the articles

The **main problems**, targeted in the articles (figure 8), relate to: lack of skills and knowledge to develop strategies, which would improve early childhood outcomes; prevention and dealing with different behavioural disorders; prevention and dealing with negative parenting practices, such as corporal punishment, physical and emotional violence, sexual abuse, emotional and physical neglect; 'the impact of adversity and trauma on child development, behaviour and lifelong health, in order to promote resilience in the paediatric setting' (Svendsen et al., 2020); focus on the scope of the problem with negative parenting practices in terms of impact for the whole society.

Figure 9 Main problems, targeted in the articles



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'Every day, almost one billion children around the world experience violent punishment. Eliminating all violence against children is a key target of the United Nations' 2030 Agenda for Sustainable Development. This is a monumental challenge due to the diversity of cultural, economic, and social contexts, in which children live. Violence-prevention programs developed in wealthy countries cannot be assumed to be transferable to low- and middle-income countries' (Durrant et al., 2017). Four of the goals of the United Nations' 2030 Agenda for Sustainable Development are: to end hunger, achieve food security and improved nutrition; ensure healthy lives and promote well-being; ensure inclusive and equitable quality education and promote lifelong learning; promote peaceful and inclusive societies for sustainable development.

In many of the articles, data regarding the **significance of the problems,** is reviewed in detail. According to Vázquez Álvarez (2017, p. 11), 'there is evidence of a relationship between positive parenting and children's development in different socioeconomic contexts. Coercive parental behaviours have been related to children experiencing difficulties in self-regulation and aggressiveness, while warmth and effective parental communication have been associated with positive child development.'

In Shah's view (2016, p.180), 'early childhood development can profoundly affect a child's educational trajectory and subsequent life-course. For example, early childhood deficits in language, cognition, and social-emotional development can lead to lower academic skills on kindergarten entry. The deficit gap widens as a child progresses through school, resulting in diminished reading and math performance, decreased graduation rates, and lower educational attainment.'

According to Hahlweg et al. (2010, p. 2), 'behavioural and emotional disturbances are very common among children and adolescents. Approximately 20% of children in western, industrialized countries experience the signs and symptoms that constitute internalizing (e.g. anxiety/depression, withdrawal) or externalizing (e.g. oppositional defiance, aggression) DSM-IV disorders. Left untreated, externalizing disorders in childhood tend to persist and evolve into more antisocial behaviours in adulthood. Similarly, childhood internalizing disorders place these

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individuals at higher risk for persistent anxiety and depressive disorders in adolescence and adulthood. In addition to the costs of treating such problems, social costs include school dropout, unemployment, family breakdown, drug and alcohol misuse, and increased delinquency and risky behaviours. The life-course persistent pathway from childhood to adult disorders may be best interrupted early in life when these behavioural patterns are more easily modified. Family risk factors, such as a lack of a positive relationship with parents, insecure attachment, harsh or inconsistent discipline practices, marital problems, and parental psychopathology increase the risk that children will develop major behavioural and emotional problems.'

In the article of Weaver et al. (2019) it is noted that, although the role of paediatricians as a source of information for parents of small children is very important, the limitations of the clinic environment may not allow for sufficient anticipatory guidance and preventive care. 'There is data that shows that almost one third of child visits are conducted in less than 10 minutes and the length of visit time is directly associated with more opportunities for anticipatory guidance, psychological risk assessment and greater ratings of family-centred care' (ibid).

When it comes to the roles of paediatricians, another article (Svendsen, 2020) also comments on the fact that support for parents for ensuring secure attachments is very important, but it is often not a formal part of paediatric medical education and training. 'Although attachment disorders have been described in the literature since the 1950s, there was little research or exploration of the topic until the mid-1990s. Paediatric medical providers are often confused by the terminology, scope, evolution, and significance of attachment and attachment disorders within the clinical setting. That need not be the case. By gaining some comfort with the fundamental features of attachment and simple ways to foster it through positive parenting practices, paediatric medical providers have a unique opportunity to promote resilience skills in children and their caregivers' (ibid, p.16). Evidence in the article of Shan et al. (2019, p. 35), is that high frequency of positive child interactions has a positive effect on child psychological functioning. The last article points to a body of research evidence that corporal punishment is widespread as a disciplining method across the USA (Hornor et al., 2020, p. 138)

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Some of the barriers, emphasized in the articles, are related to the importance of promoting positive parenting in a time of economic crisis due to the fact that tensions within the family may increase due to the unemployment and general economic insecurity, which will influence relationships with children.

In summary, it is important to point out, as one of the articles emphasizes, that there is evidence of a relationship between positive parenting and children's development in different socioeconomic contexts. Coercive parental behaviours have been related to children experiencing difficulties in self-regulation and aggressiveness, while warmth and effective parental communication have been associated with positive child development (Vázquez Álvarez, 2017, p. 11).

The identified problems, outlined above, provide a framework for **the purposes** of the studies. These are related to: outlining different initiatives of positive parenting, the importance of developmental and educational science for family and society in general; 'differences in parenting skills, social support, children's behaviours and parental stress pre, immediately, post and six months post intervention; identifying mechanisms by which the intervention is related to changes in the four outcomes examined' (Vázquez Álvarez et al., 2017); the relevance of Positive Discipline in Everyday Parenting (PDEP), parents' satisfaction with the program and their perceptions of its impact on their parenting; measuring the effectiveness and efficiency of parenting practices on primary based care intervention; measuring the effectiveness of the Triple P program; measuring the effectiveness and impact on parents' behaviour of the Rise Up program; building childhood resilience in paediatrics; exploring the prevalence and the combined effects of maltreatment and frequency of parent-child interactions on psychological well-being.

The analysed articles study specific effects from programs for development of parental skills for positive parenting and violence prevention or ways to change paediatric practices or policies. In some of the articles, concrete recommendations regarding development of programs and services are discussed.

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Problem solutions

As a **problem solution**, the first article indicates the Positive Parenting Recommendation. 'To improve the way support is delivered to at-risk families, experts recommend several measures: (a) parent support should be provided as an integrated part of policy development; (b) formal support should be universally available and provided in a non-stigmatizing way; (c) informal support should be promoted by creating and strengthening existing social bonds and encouraging new links between parents and their family, neighbours and friends; and (d) vulnerable families also need to strengthen their bonds to community life by empowering parents' and children's associations and NGOs and activating a range of self-help and other community-based groups and services' (Rodrigo, 2010, p. 288). The Positive Parenting Recommendation 'considers that the task of parenting should be defined within the framework of children's and parents' rights and obligations. The goal of parenting is to promote positive parent–child relationships, founded on the exercise of parental responsibility, to optimize the child's potential development and wellbeing. Therefore, parents need to become more aware of the nature of their role, their children's rights, and the responsibilities and obligations that derive from these and their own rights' (ibid, p. 282).

Most of the problems, described in the articles, are connected with implementation of concrete programs, services, and interventions in view of improvement of parental skills. For instance, some of these programs are implemented in different group forms, such as the program analysed in the article of Vázquez Álvarez (2017) whose goal is to provide knowledge regarding children's development to parents and to develop their skills for effective parenting, so that they can use appropriate disciplinary methods[34].

[34] https://journals.copmadrid.org/pi/art/10.1016/j.psi.2016.02.004

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In the article of Durrant et al. (2017), the problem solution is in itself the program **Positive Discipline in Everyday Parenting**.[35] This 'program is designed around four key themes: 1) shifting parents' goals from immediate child compliance to long-term learning; 2) strengthening parents' understanding of the importance of simultaneously providing warmth (physical and emotional security) and structure (scaffolding of children's learning) in all situations; 3) increasing parents' knowledge of children's neurobiological, emotional, and behavioural development from birth to adolescence; and 4) helping parents integrate these components to develop problem solving strategies to replace physical and emotional punishment in times of conflict with their children. The parent program is typically delivered over eight 2-hour sessions, plus a follow-up session held 2 to 3 weeks after the program ends. It is delivered on a non-profit basis through community agencies by trained facilitators to groups ranging from 5 to 20 participants' (ibid, p. 524).

Positive Discipline in Everyday Parenting

The PDEP program is **based on the theory** that a person's behavioural beliefs determine whether the person perceives that behaviour as positive or negative. It is designed to reduce parents' approval of physical punishment by increasing their understanding of: i) the long-term developmental risks of physical punishment, and ii) the long-term developmental benefits of trust, attachment, and communication. This is **achieved by** enhancing parents' knowledge and skills through a series of interactive activities and problem-solving exercises that build on their existing strengths. **Currently, in some form, the PDEP programme has been used in 30 countries**, with support from the not-for-profit organisation (Positive Discipline in Everyday Life - PDEL) that have developed the programme and financial support, in the main, from Save the Children Sweden. To date, there has been a lack of evidence that PDEP works at the long-term outcome level. In terms of the most important long-term outcome, children's well-being, this evaluation shows **that the program works**. It also works when considering caregiver behaviour.

[35] https://resourcecentre.savethechildren.net/node/7509/pdf/pdep_2016_4th_edition.pdf

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Other articles describe an analysis of different interventions, provided through home visits or centre-based programs (Shah et al., 2016). For instance, **Healthy Steps** (HS)[36] included community and hospital-based sites; all other interventions took place in hospital-based clinics. Paediatricians or primary care providers delivered 3 of the interventions were delivered by developmental specialists or professionals, such as a nurse practitioner or social worker (Ibid, p.42–48). Most of the interventions were delivered individually to parents, but also in a group format incorporated a parent group as part of its structure. In the Reach Out and Read (ROR) model, paediatricians deliver a book to a child during each attended paediatric well-child visit, from 6 months to 5 years of age, with brief education regarding the importance of shared reading. In the first intervention, the Video Interaction Project (VIP), a developmental specialist reviewed videotaped interactions between a mother and her child, discussed development, and provided learning materials and written pamphlets to enhance parenting practices (ibid, p.9).

Healthy Steps

Healthy Steps partners with pediatric primary care providers to support parents and improve the health and well-being of babies and toddlers so they are prepared for school and life. Healthy Steps is a population-based, risk-stratified model that helps to operationalize and enhance the American Academy of Pediatrics. The Healthy Steps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening, provide successful interventions, referrals, and follow-up to the whole family. Healthy Steps Specialists build strong relationships with families and providers and the lives of children and families improve. Because of Healthy Steps, families receive early preventive services and the entire practice also benefits–Healthy Steps increases the efficiency of the medical system and supports team-based comprehensive care.
HealthySteps has demonstrated positive outcomes for children, their families, and the physicians and practices who serve them.

Two of the reviewed articles are dedicated to the **Triple P program**[37] (Sanders et al., 2003; Hahlweg et al., 2010). 'The Triple P-Positive Parenting Program developed by Sanders and colleagues is an example of a population- based, multilevel approach to parenting intervention,

[36] https://www.healthysteps.org/the-model
[37] https://www.triplep.net/glo-en/home/

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based on the above-mentioned principles. The Triple P system has five different levels of support for parents in raising children, and it involves a number of different delivery modalities including individual, group, telephone-assisted, and self-directed programs. This public health perspective involves identifying the minimally sufficient conditions that need to change to alter at-risk children's developmental trajectories for developing serious conduct problems and make these interventions broadly available to parents. The Triple P system is widely spread internationally and has been well evaluated' (Hahlweg et al., 2010, p. 2).

Triple P program

The Triple P – Positive Parenting Program is one of the most effective evidence-based parenting programs in the world, backed up by more than 35 years of ongoing research. Triple P gives parents simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behavior and prevent problems developing. Triple P is used in more 30 countries and has been shown to work across cultures, socio-economic groups and in many different kinds of family structures. No other parenting program in the world has an evidence base as extensive as that of Triple P. It is number one on the United Nations' ranking of parenting programs, based on the extent of its evidence base. Triple P's body of evidence is the most extensive of any parenting program. Triple P has been part of more than 650 trials, studies and published papers, including more than 340 evaluation papers, 174 of which are randomized controlled trials [55% (189) of evaluation studies have no developer involvement].

Several studies, related to change in the paediatric practices and inclusion of additional topics, connected with positive parenting, have been identified. Such a study is the one of Weaver et al., (2019) in which is described 'the Vision of Paediatrics for 2020 from the American Academy of Paediatrics' (ibid, p. 2-3). According to this Vision, there are 'eight megatrends that will challenge the field of paediatrics in the near future' (ibid, p. 2-3). Such is the **RISE Up! Program**. Its content 'was developed through extensive formative work and informed by the guidelines of the American Academy of Paediatrics, building upon the five protective factors that have been shown to decrease child abuse and neglect (U.S. Department of Health and Human Services, 2008). Specifically, the tailored feedback provided direct behavioural guidance to promote nurturing and attachment, knowledge of child development, parental resiliency, social connection, and use

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of concrete supports, within the context of unintentional injury prevention recommendations. Each caregiver received messages from an integrated message library; for example, a caregiver might be encouraged to make bath time a meaningful experience by both talking to their child (promoting nurturing and attachment) and by carefully supervising their child by avoiding distractions (decreasing risk of drowning). health communication programs have become an important component of preventative care, generally, and have demonstrated efficacy across a variety of health topics. The RISE Up! program was housed on a tablet computer and consisted of the baseline assessment and the algorithms that produced tailored feedback to caregivers. The report was tailored to the caregiver's self-selected parenting situation, two unintentional high-risk injury areas, and micro tailored to the personal characteristics of the caregiver and child (e.g., the report used the child's name, appropriate pronouns and referenced the specific age of the child). Based on the assessment, a RISE Up! tailored report was generated and printed for each caregiver. Very specific behavioural recommendations were offered to address both the highest-stress parenting situation and the two priority unintentional injury areas. These topics were selected from formative research during program development phase. Further, the report listed these high priority topics to inform the anticipatory guidance of the paediatrician so that discussion during the patient visit could focus on the injury and parenting topics that most warranted discussion. The content of RISE Up! was developed through extensive formative work and informed by the guidelines of the American Academy of Paediatrics, building

RISE Up

The RISE Up! program was housed on a tablet computer and consisted of the baseline assessment and the algorithms that produced tailored feedback to caregivers. The report was tailored to the caregiver's self-selected parenting situation, two unintentional high-risk injury areas, and micro tailored to the personal characteristics of the caregiver and child (e.g., the report used the child's name, appropriate pronouns and referenced the specific age of the child). Based on the assessment, a RISE Up! tailored report was generated and printed for each caregiver. Very specific behavioral recommendations were offered to address both the highest-stress parenting situation and the two priority unintentional injury areas.

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upon the five protective factors that have been shown to decrease child abuse and neglect (U.S. Department of Health and Human Services, 2008). Specifically, the tailored feedback provided direct behavioural guidance to promote nurturing and attachment, knowledge of child development, parental resiliency, social connection, and use of concrete supports, within the context of unintentional injury prevention recommendations' (ibid, p.2).

The article of Svendsen (2020) discusses the need for paediatricians to apply knowledge and skills in order to support and develop caregivers' skills within a clinical setting.

The last article views the problem solution as an intervention on behalf of paediatric nurse practitioners who can help parents develop skills for positive parenting (Hornor et al., 2020).

In summary, the problem solutions, analysed in the articles, focus on group programs for positive parenting, individual type of programs, combined programs like Triple P, different software tools, etc. The main characteristics of these group decisions are a multidisciplinary approach and combining the efforts of different professional – health, social and educational to develop the skills of beneficiaries for positive parenting (figure 9).

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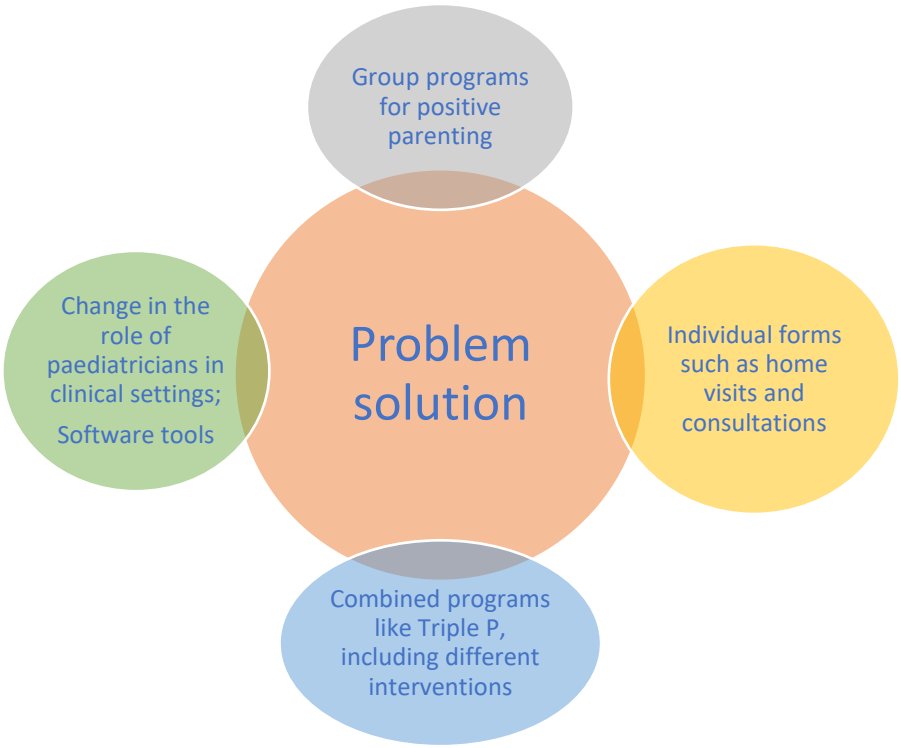
Figure 10 Problem solutions



Conceptual framework

Conceptual frameworks are used in some of the articles. Most of them use concepts such as positive parenting, maltreatment, attachment, resilience, corporal punishment. Moreover, most articles use an ecological framework, which analyses the task of parenting that considers children in relation to their family, neighbourhood, the larger social structure, and economic political and cultural environment. Therefore, the parenting task needs social support to be adequately performed (Rodrigo, 2010).

The rights-oriented approach forms the theoretical basis in the article of Durrant et al. (2017), which indicates the basic principles of the Positive Parenting program, such as rights-oriented, child-centred, and universal principles.

Additionally, in some of the articles, such as the one of Hornor et al. (2020), paediatric nurse practitioners are viewed as a part of the ecosystem together with schools, child protective services and community programs, supporting positive parenting.

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The eco-bio-developmental framework is used from other authors like Shah et al. (2016). He views the socio-cultural learning as crucial in promoting ECD.

Study design and methodology. Findings

The **study design and methodology as well as findings** are presented in a different way in the different articles, related to the purposes and conceptual frameworks of the research.

The study design and methodology of the reviewed studies have several general characteristics. Mainly quantitative data is collected, with experimental or quasi-experimental design. Many instruments for data collection have been employed, among which are scales for measuring parental competence – lifestyle evaluations, preschool evaluations, etc. Also, socio-demographical questionnaires, child behaviour checklists, caregiver teacher report, positive parenting questionnaires, as well as self-reported and pre-test questionnaires and other instruments are indicated.

Several of the articles make a **desk review of available policies** (Rodrigo, 2010; Svendsen et al., 2020). Svendsen et al. make a desk review of the usage of attachment, relationship, and positive parenting principles of paediatric practices. **The findings** in the article of Svendsen et al. (2020) regarding attachment and resilience 'defined as a dynamic process of positive adaptation to or despite significant adversities' shows that the paediatric medical provider has a unique opportunity to promote attachment at every visit. We can project to the caregiver a confident expectation that they can effectively support their child, foster secure attachment, and help the child to achieve these necessary skills (Svendsen at all, 2020, p. 26)

The article of Rodrigo (2010) reviews the European Policy Recommendation. This Recommendations aim to make member states aware of the necessity of providing parents with sufficient support mechanisms to meet their important responsibilities in bringing up their children. Member states are called upon to support parents in their upbringing tasks through: (a) adequate family policies that provide the necessary legislative, administrative and financial measures to create the best possible conditions for positive parenting; (b) the provision of

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services to support parents such as local counselling services, help lines and educational programmes; and (c) specific services for parents in situation of risk to prevent the unnecessary displacement of children due to maltreating parental behaviour (Rodrigo, 2010). In the **article a conclusion is made** regarding a rich variety of ways of providing emerged parenting support programs in Europe. 'EU Member States are devoting increasing attention to parenting support policies and programmes by introducing a family support dimension in the provision of health services, in particular those related to family planning, pregnancy and the rearing of new-born children. The universality and gratuity of health services and social services is also a clear asset in Europe. There is a focus on empowerment of parents and families in the context of family–services partnerships in order to avoid services becoming a substitute for parents and their responsibilities. Finally, services are usually provided by professionals and mostly delivered through community centres. Two limitations are also mentioned in the survey: the lack of consolidation of these initiatives and their limited availability in terms of geographical distribution due to budget limitations and the difficulty in networking among the different help providers' (ibid, p. 289).

Almost all the other authors use **quantitative methods for data collection**. A quasi-experimental or experimental design is usually used. The control groups are used to make conclusions regarding the effectiveness of the programs. Some the programs have systems for collecting input and output data. Some have self-reported questionnaires, while others have additional surveys that are not self-reported. It is important that many of the programs have pre-assessment components. For example, in the study of Hahlweg et al. (2010), 'families with children age 3 to 6 years were recruited out of preschools in the city of Braunschweig, Germany. The assessments for each family consisted of a battery of self-report questionnaires. At pre-assessment, families provided information regarding their age, nationality, exact relationship to the child, education level, employment, receipt of social welfare assistance, and household income. In addition, they provided data on the age and gender of the child of interest and any siblings. The parent training Triple P was introduced to families randomized to the experimental group; the control group was not offered training and was naturally observed for the course of

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the study' (ibid, p. 5). According **to the findings** in his article, 'at the 2-year follow-up, both parents in the Triple P intervention reported significant reductions in dysfunctional parenting behaviour, and mothers also reported an increase in positive parenting behaviour. In addition, mothers reported significant reductions in internalizing and externalizing child behaviour. Single-parent mothers in the Triple P intervention did not report significant changes in parenting or child problem behaviour, which is primarily due to inexplicable high positive effects in single parent mothers of the control group. Neither mother-child interactions, nor teacher ratings yielded significant results' (ibid, p.1).

One of the studies is defined as derivative large-scale Shanghai **population survey** (Shan et al, 2019). This means, that the so-called 'Big Data', which is, naturally, representative, is collected and analysed. According to **the findings of** Shan et al. (2019), 'the prevalence of parent-reported child maltreatment in Shanghai was 2.70 %. A history of maltreatment increased the risk of total difficulties and prosocial problems. A high frequency of positive parent–child interaction had a moderating effect on the correlation between maltreatment and prosocial problems. Maltreated children had an increased risk of developing psychosocial problems, particularly those with a low frequency of positive parent–child interactions. A higher frequency of positive parent–child interactions may be associated with fewer adverse outcomes in maltreated children (ibid, p.180). 'Parent–child interaction had no effect on the association between maltreatment and total difficulties, which indicated that positive parent–child interaction positively affected total difficulties, regardless of the history of maltreatment' (ibid, p.184). 'The study found that socioeconomic status, family environment, and child characteristics affected the prevalence of maltreatment. Lower socioeconomic status, having a father as the main caregiver, being not an only child, parental divorce, or separation, having been born preterm, and having a history of hospitalization increased the risk of maltreatment, which is consistent with results from previous studies. Findings 'also demonstrated that being maltreated can had an adverse impact on psychosocial well-being across a variety of domains (e.g., emotional problems, conduct problems, hyperactivity, peer problems, and prosocial problems) in 3- to 4-year-old children. However, those previous findings have not yet been tested in large population studies. Our

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findings provided strong support for the views about the detrimental impact of maltreatment on mental health at an early stage of life' (ibid, p.184).

Only in one of the studies, **qualitative methods have been used as addition to the quantitative**. These methods are interviews and focus groups with professionals who took part in the parent training program (Vázquez Álvarez et al., 2017). According to **the findings of** Vázquez Álvarez (2017), the Parenting Program in Spain has improved significantly in view of all outcomes for the parents who took part in it. 'Compared, all four outcomes improved significantly. 76% of the participants improved their parenting skills and 61% had improved levels of social support. 56% had reduced children's negative behaviours and 66% - in parental stress. All outcomes maintained this significant improvement. Parents and professionals describe different changes in parents' parenting skills, stress, and social support after participation in the PSP, and in their children's behaviours. Some subcategories emerged after analysing parents' and professionals' discourses. Data came from 22 groups of 10-14 parents with a child 2-12 years old. Most parents were married or cohabiting, almost one third were 36-40 years old; 40% were immigrants, mostly from Latin-American countries; one quarter had primary studies or less and 31% were unemployed' (ibid, p. 12). 'Our study is consistent with others reporting that parent training programs have positive short-term quantitative effects. However, there are fewer mixed and follow-up studies evaluating effects in parental psychosocial health or on children's behaviours' (ibid, p. 13). 'The reduction observed in children's negative behaviours, such as aggressiveness or defiance, but also the increase in children's positive behaviours, was consistent with studies from other countries (immediately and six months after the intervention). Children's improvement in their ability to express feelings and communicate with their environment, understand parents demands or improve some habits (sleeping, hygiene or others) have been previously reported. Previous studies also show that changes in children should be understood as a consequence of changes in parenting' (ibid, p.13).

In terms of the program 'Positive Discipline in Everyday Parenting'**, the findings of** Durrant et al. (2017) show that the parents are mostly or very satisfied with the program, the materials and

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activities provided. The majority of parents beneficiaries of the program said that it has a positive impact on their parenting skills and abilities. They shared that the program 'helped them to understand their children's development and feelings, communicate better with their children, control their anger, and build stronger relationships with them. PDEP is a promising tool for preventing punitive violence against children across human development contexts. More than 80% of parents in each category believed that PDEP will help them to use less physical punishment' (ibid, p.529).

When it comes to the program Healthy Steps, Shah et al. (2016, p.4) describe their findings in a following way: the program 'All studies used continuous outcomes and results demonstrated a significant positive aggregate effect for primary care–delivered interventions on parent-child interactions. **The data shows that** higher percentage of parents that received the intervention reported following routines and using less severe discipline (ibid, p.9) Many of the studies included in this review evaluated the impact of the intervention on early childhood language development. Consequently, there have been an increasing number of interventions developed to enhance parenting practices. This systematic review highlights the diverse ways the primary care setting has been used to disseminate these interventions (ibid, p.10)

The findings of Weaver et al. (2019) about the Rise Up program, show that 'A follow-up assessment was completed with 125 parents (58%) about six weeks after the paediatric visit. Overall, 75% of parents reported trying at least one of the recommendations included in the report. Analysis of parenting risk indicated that 53% of parents had different highest parenting risk areas after RISE Up! and 33% of identified parenting risk scores decreased after RISE Up! Of the 231 priority unintentional injury risk behaviours identified, 34% were reported as non-risk behaviours at follow-up. Race and education were significantly associated with program effects in bivariate analysis; program effects were also correlated with communication mediators in a strong dose-response relationship. Reducing both child abuse and neglect and paediatric unintentional injuries are global priorities. Several childhood injury prevention frameworks and evidence-based policy recommendations highlight shared etiologies and opportunities for

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intervention. RISE Up! shows promise for universal prevention to promote the adoption of parenting practices to reduce injury risk and positive parenting behaviours' (Weaver et al. 2019, p. 1)

Figure 11 Findings

Recommendations in the articles

The recommendations in the analysed studies vary in terms of scope. In Shan's view, 'further research is needed to investigate different types of maltreatment. This study only measured the frequency of positive parent– child interactions, but not the quality of interaction, which is equally important for children's psychosocial well-being. However, the quality of parent–child interaction is hard to be evaluated in large-scale epidemiologic studies through the use of short questionnaires. Policy makers and health professionals need to place more emphasis on promoting child protection and strengthen parents' awareness regarding the importance of positive parent– child interactions' (Shan et al., 2019, p. 185).

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According to the recommendations of Rodrigo (2010, p. 291), 'the ESDP, as a scientific society, has recently defined positive parenting as a central topic for Europe and for European developmental psychology. The European Society for Developmental Psychology (ESDP) as an international society could facilitate scientific exchanges of knowledge, experience, and good practice in the application of the guidelines on positive parenting in several European countries. Therefore, ESDP is in the position to contribute to the successful implementation of the positive parenting initiative in Europe'.

In the opinion of Durrant et al. (2017, p.530), 'there is an urgent need for systematic studies of parenting interventions to reduce parental violence in low and middle-income countries. This study was intended as a first step toward this objective. The present findings suggest that parents tend to be highly satisfied with the PDEP program and expect it to have positive impacts on their parenting, regardless of human development context. This evidence provides a strong foundation for moving forward with an expanded and more in-depth evaluation of the program using multiple methods within and between countries.'

According to the recommendations of Shah et al. (2016), 'the paediatric primary care setting offers an innovative platform to disseminate parenting interventions and shows promise in enhancing parenting behaviours that promote early child development' (ibid, p. 12). 'Understanding how to more effectively enhance parenting behaviours and incorporate strategies for doing so into the primary care setting should continue to be rigorously investigated. Additional studies that use standardized measures for assessing parenting and early childhood outcomes also will be necessary to clearly define the impact of such interventions' (ibid).

Another recommendation in this focal point of advocacy is that 'the primary goal for universal prevention should be focused on increasing recruitment and engagement of families in prevention programs and not so much in developing new programs which may or may not be effective. In terms of efficacy, there is sufficient data to assume that parenting programs are efficacious in changing self-reported parenting and maternal-reported child behavior problems.

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Many prevalence studies rely on this type of data and thus, it seems appropriate to conclude that universal prevention is worth the effort' (Hahlweg et al., 2010, p.12).

The recommendation of Weaver focuses on the Rise Up program. 'Similar to unintentional injury prevention, which has been considered by previous health communication programs, approaches to address child maltreatment must target specific caregivers' behaviors – behaviors that are protective and help establish a strong connected relationship between caregiver and child and are associated with decreased rates of child abuse and neglect. To decrease rates of child maltreatment, we must focus our interventions on addressing malleable risk factors. RISE Up! offers a tool for promoting these positive parenting behaviors known to support children and families' (Weaver et al., 2019, p.6)

In summary, the topic of positive parenting is quite actively appearing and commented on in the last years in relation to ensuring a safe and secure environment for raising and supporting children in their development. The development of parental skills, in spite of being a part of different programs for HV, is also supported by programs, focused directly on positive parenting in the best interest of the child. The studies of different programs related to positive parenting should be continued. It is also necessary to develop new evidence base for policy making, in order to support the effort of ensuring a safe and secure environment for children's development.

5.4. ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line

Overview of the articles

Sixteen articles have been reviewed in this area. The data from the analysis shows that most of the articles are based on an integrated approach, including nutrition component as well as other supportive activities, which confirms the findings from the first report that programs containing only a nutrition component are very rare. Therefore, the two focal points of advocacy have been merged together. The analysis of the findings will be presented in general for the policy area of

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the nurturing care framework. Four of the articles are related to practices from the first part of the study: Healthy Start, implemented in the UK[38] and WIC (women, infants, children)[39], implemented in USA. The key demographic characteristics of all of the articles in this focal point of advocacy are presented in table 8.

Table 8 Articles in the focal point of advocacy 'ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line'

№	Author/s & year of publication	Publication details and link to abstract or full text (if available)	Country/state of study and/or program implementation
1	Black, M. M. (2004)	Black, M. M., Cutts, D. B., Frank, D. A., Geppert, J., Skalicky, A., Levenson, S. & Meyers, A. F. (2004). Special Supplemental Nutrition Program for Women, Infants, and Children participation and infants' growth and health: a multisite surveillance study. Pediatrics, 114(1), 169-176 https://pediatrics.aappublications.org/content/114/1/169 (full text)	USA
2	Black, M. M., (2004)	Black, M. M., & Dewey, K. G. (2014). Promoting equity through integrated early child development and nutrition interventions. Annals of the New York Academy of Sciences, 1308(1), 1-10. https://nyaspubs.onlinelibrary.wiley.com/doi/10.1111/nyas.12351 (full text)	International (review article)
3	Black, M. M (2015)	Black, M. M., Pérez-Escamilla, R., & Fernandez Rao, S. (2015). Integrating nutrition and child development interventions: scientific basis, evidence of impact, and implementation considerations. Advances in Nutrition, 6(6), 852-859. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4642432/ (full text)	International (review article)
4	Gosliner W. (2020)	Gosliner, W., & Shah, H. (2020). Participant voices: examining issue, program and policy priorities of SNAP-Ed eligible adults in California. Renewable Agriculture and Food Systems, 35(4), 407-415. Published online by Cambridge University Press https://www.cambridge.org/core/journals/renewable-agriculture-and-food-systems/article/participant-voices-examining-issue-program-and-policy-priorities-of-snaped-eligible-adults-in-california/C2DC13E00F525AAEEA7367D36BE31768 (full text)	USA
5	Gowani, S. (2014)	Gowani, S., Yousafzai, A. K., Armstrong, R., & Bhutta, Z. A. (2014). Cost effectiveness of responsive stimulation and nutrition interventions on early child development outcomes in Pakistan. Annals of the New York Academy of Sciences, 1308(1), 149-161 https://nyaspubs.onlinelibrary.wiley.com/doi/10.1111/nyas.12367 (full text)	Pakistan

[38] Healthy Start/Home/For health professionals/Your role, retrieved from: https://www.healthystart.nhs.uk/for-health-professionals/your-role/

[39] Center on Budget and Policy Priorities, (2017), WIC Works: Addressing the Nutrition and Health Needs of Low-Income Families for 40 Years, retrieved from: https://www.cbpp.org/research/food-assistance/wic-works-addressing-the-nutrition-and-health-needs-of-low-income-families

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6	Haselow, N. J. (2016)	Haselow, N. J., Stormer, A., & Pries, A. (2016) Evidence-based evolution of an integrated nutrition-focused agriculture approach to address the underlying determinants of stunting. Maternal & Child Nutrition, 12, 155-168. https://pubmed.ncbi.nlm.nih.gov/27187913/ (full text)	Asia
7	Liu, Y. H., (2012)	Liu, Y. H., & Stein, M. T. (2012). Feeding behaviour of infants and young children and its impact on child psychosocial and emotional development. Encyclopedia on early childhood development. Montreal: Centre of Excellence for Early Childhood Development and Strategic Knowledge Cluster on Early Child Development. http://www.child-encyclopedia.com/child-nutrition/according-experts/feeding-behaviour-infants-and-young-children-and-its-impact-child (full text)	International (review article)
8	Lovelace, S. (2015)	Lovelace, S., & Rabiee-Khan, F. (2015). Food choices made by low-income households when feeding their pre-school children: a qualitative study. Maternal & child nutrition, 11(4), 870-881. https://onlinelibrary.wiley.com/doi/full/10.1111/mcn.12028 (full text)	UK
9	McFadden, A., (2014)	McFadden, A., Green, J. M., Williams, V., McLeish, J., McCormick, F., Fox-Rushby, J., & Renfrew, M. J. (2014). Can food vouchers improve nutrition and reduce health inequalities in low-income mothers and young children: a multi-method evaluation of the experiences of beneficiaries and practitioners of the Healthy Start programme in England. BMC public health, 14(1), 1-13. https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-148 (full text)	UK
10	Ng, S. W., (2018	Ng, S. W., Hollingsworth, B. A., Busey, E. A., Wandell, J. L., Miles, D. R., & Poti, J. M. (2018). Federal nutrition program revisions impact low-income households' food purchases. American journal of preventive medicine, 54(3), 403-412 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5820777/	USA
11	Prado, E. L., (2014)	Prado, E. L., & Dewey, K. G. (2014). Nutrition and brain development in early life. Nutrition reviews, 72(4), 267-28 https://academic.oup.com/nutritionreviews/article/72/4/267/1859597 (full text)	International (review article)
12	Rivera, J. A (2004)	Rivera, J. A., Sotres-Alvarez, D., Habicht, J. P., Shamah, T., & Villalpando, S. (2004).). Impact of the Mexican program for education, health, and nutrition (Progresa) on rates of growth and anemia in infants and young children: a randomized effectiveness study. Jama, 291(21), 2563-2570. https://www.researchgate.net/publication/8533942_Impact_of_the_Mexican_Program_for_Education_Health_and_Nutrition_Progresa_on_Rates_of_Growth_and_Anemia_in_Infants_and_Young_Children_A_Randomized_Effectiveness_Study (full text)	Mexico
13	Silva, G. A., (2016)	Silva, G. A., Costa, K. A., & Giugliani, E. R. (2016). Infant feeding: beyond the nutritional aspects. Jornal de pediatria, 92(3), 2-7. https://reader.elsevier.com/reader/sd/pii/S0021755716000474?token=81E129401FE38C12710E286DD5CD83FEB1D6A841E1493FE270CB1C7A4CFBA0B2CAD509D2E6E50949A1D2D49B5C525556 (full text)	International (review article)
14	Shahnaz (2016)	Shahnaz Vazir*, Patrice Engle, Nagalla Balakrishna, Paula L. Griffiths§,Susan L. Johnson¶, Hilary Creed-Kanashiro, Sylvia Fernandez Rao, Monal R. Shroff and	India

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	Vazir (2012)	Margaret E. Bentley (2012),Cluster-randomized trial on complementary and responsive feeding education to caregivers found improved dietary intake, growth and development among rural Indian toddlers https://onlinelibrary.wiley.com/doi/full/10.1111/j.1740-8709.2012.00413.x (full text)	
15	Watt, T. (2015)	Watt, T. T., Appel, L., Lopez, V., Flores, B., & Lawhon, B. (2015). A primary care-based early childhood nutrition intervention: evaluation of a pilot program serving low-income Hispanic women. Journal of racial and ethnic health disparities, 2(4), 537-547 https://link.springer.com/article/10.1007/s40615-015-0102-2 (full text)	USA
16	Wilson, A. C. (2015)	Wilson, A. C., Forsyth, J. S., Greene, S. A., Irvine, L., Hau, C., & Howie, P. W. (1998). Relation of infant diet to childhood health: seven year follow up of cohort of children in Dundee infant feeding study. Bmj, 316(7124), 21-25. https://www.researchgate.net/publication/13779989_Wilson_AC_Forsyth_JS_Greene_SA_Irvine_L_Hau_C_Howie_PW_Relation_of_infant_diet_to_childhood_health_seven_year_follow_up_of_cohort_of_children_in_Dundee_Infant_Feeding_Study_BMJ_316_21-25 (full text)	Scotland

The main demographic characteristics of the articles include **country (countries), in which the program is implemented, target group(s), year of the study, who conducted the research.** The countries of the evidence-based policies from the articles are the following: USA, UK, Mexico, Pakistan, Brazil, India, Scotland. Most of the programs are American, since there is a scientific community, dedicated to conducting research in these areas and since most of the programs are implemented in USA. When it comes to the target group, the analysis shows that, apart from targeting low-income families, they are also oriented towards children in general, women with children in particular, pregnant women and children in rural areas. The years of publishing of the articles are in the period between 1998 – 2018. Most of the articles are based on research, conducted by public universities and health institutes.

Main identified problems and purposes of the articles

There are several **problems**, reviewed in the articles. According to Rivera et al. (2004, p. 2563), malnutrition causes death and impaired health in millions of children. Black et al. (2015, p. 852) discuss that 'in the past 15 years, there have been unprecedented successes, including improvements in poverty reduction, child and maternal survival, primary education enrolment, gender equality, HIV treatment, availability of clean water, and global partnerships'. At the same time, they claim that 'many inequities remain, particularly for young children in low-and middle-

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income countries' (ibid.). Haselow et al, (2016, p.155) investigate the integrated nutrition focused agriculture approach and consider that 'despite progress in reducing hunger and malnutrition since the 1990s, many still suffer from undernutrition and food insecurity, particularly women and young children, resulting in preterm birth, low birthweight and stunting, among other conditions'.

According to McFadden et al., (2014, p.2), who have studied the effect of a voucher program, 'the problems with malnutrition exist, because of insufficiency of financial resources' and 'it is difficult for low-income families to prioritize spending on healthy food'. The research of Gosliner & Shah (2020, p. 407) focuses on the educational program for families SNAP Education (SNAP-Ed). The problem, stated in the article, is that 'most recipients lack adequate financial resources to meet their needs; that families utilize multiple strategies to make their food resources last, but often run out of food and/or limit their diets' (ibid., p. 407).

Some articles define the problem as connected with the importance of adequate nutrition for the child brain or a need for nutrition to be examined within all its aspects. Silva et al. (2016, p. 1) state that 'infant feeding is a subject that has aroused great interest in recent years in several fields of knowledge, as it involves different aspects beyond nutrition' and review the interaction between child and caregiver as an essential component.

A specific problem in the context of the country where the program is implemented is 'inadequate feeding and care, which 'may contribute to high rates of stunting an underweight among children in rural families in India' (Vazir et al., 2012, p. 1). Wilson et al. (1998, p.21) describe a problem in the context of their research as 'in the United Kingdom 64% of infants are breast fed initially, with only 19% still being breast fed at 4 months of age. Additionally, 90% of infants start eating solid foods before the age of 4 months'.

In the article of Lovelace & Rabiee-Khan, (2015, p.1) barriers against healthy eating of low-income families are researched and it is emphasised that 'the growing concern about poor dietary practices among low-income families has led to a 'victim blaming' culture that excludes wider social and environmental factors'. The authors inform that some parents have good knowledge

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about what constitutes a healthy diet, but find it difficult to apply their knowledge, since there are conflicting messages, which they receive (Lovelace & Rabiee-Khan, 2015).

In terms of content, the studies address the need for more evidence on the effects of the programs. Black et al. (2004) claims that little is known about the effect of WIC on infant growth, health, and food security, which is important for financing of the program. This gap is also recognised by Ng et al. (2018), who have revised food packages of nutrition program and state that there isn't enough evidence, regarding the effect of the program. Watt et al. (2015, p. 537) support this opinion and claim that 'research on broadly defined pre/postnatal nutrition interventions is sparse'. In the article investigating the effect of a nutritional program for Hispanic women, the author determines the problem connected with low-income minority children, exhibiting disproportionately high rates of physical and developmental problems. 'Inadequate nutritional intake during pregnancy and infancy is a factor that contributes to these disparities in child health'(ibid, p.537). Rivera et al. (2004, p. 2564) state that „little information is available on the effectiveness of large-scale programs'. Govani et al. (2014, p. 149.) consider that „few studies in developing countries calculate the effectiveness of quality early childhood interventions. '

The problems, reviewed in the articles, are related to nutrition and feeding issues, malnutrition, poor dietary practices, nutritional inequalities, difficulties to prioritize healthy food, inadequate feeding, nutritional deficiencies during pregnancy, challenges to maintain a healthy diet, nutritional interventions, nutrition in the first years, breastfeeding, introduction of solid food, food insecurity. Single interventions targeting ECD or nutrition can be effective, but there is limited evidence regarding the development, implementation, evaluation, and scaling up of integrated interventions (Black et. al, 2014).

The purposes of the studies are mostly related to the effects of the programs and policies regarding different components of child development, such as weight, height, brain function, cognitive development, behaviour and productivity, linear growth, as well as importance of interactions between caregivers and children during feeding, responsible feeding, responsive stimulation and nutrition, diets of young children, effects of nutrition interventions,

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complementary feeding, core components of stunting, household purchases, health and food security (Figure 12).

Figure 12 Purposes of the studies in the articles

In addition to that, there is an identified body of evidence pointing towards the **significance of the problems**, reviewed in the articles. Studying these evidence-based programs is significant since they are very large in scope. Black et al., (2004,p. 169) investigate one of the nutritional programs in USA, which „served more than 8 million low-income people, including pregnant, postpartum, and breastfeeding women, children up to age 5 years, and 53% of all infants born in the U.S', since „WIC is the largest food supplement program in the United States, serving almost 7 500 000 participants.' The same body of evidence is related the impact of the program in Mexico, which has expanded from about 300 000 families in 1997 to approximately 2.6 million families in 2000, about 40% of rural families and 10% of all families' (Rivera et al., 2004, p. 2564).

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Another program that supports better nutrition is Healthy Start. It has supported approximately 600,000 women and children in over 450,000 families in the UK between 2006 and 2014 (Macfadden et al., 2014, p. 2).

The body of evidence regarding the significance of the programs is also related to the severity of issues for families and children. According to (Liu et al., 2012, p. 2) *'Mild and transient feeding problems occur in 25% to 35% of young children while severe and chronic feeding problems occur in 1% to 2%'.* The authors present the often-faced feeding problems as overeating, poor eating, feeding behaviour problem and unusual or unhealthy food choices and emphases that they '*are often associated with early problems in parent-child feeding experiences.'* (ibid).

McFadden et al., (2014, p. 2) discuss the evidence of the problem with feeding of poor families presenting that '*In 2012, 7% of households in the United Kingdom (UK) were reported to be unable to afford fresh fruit and vegetables and four million children and adults were estimated not to be eating a healthy diet.* The authors consider that '*the lack of nutritional knowledge and practical food preparation skills are contributory factors to poor diets in low-income families, structural barriers of affordability and access to fresh food are key.'* (ibid)

In a review of integrated child development/nutrition interventions Black et al., 2014 describe the existing problem of inequities for young children in low-and middle-income countries. The authors emphases that '*Inequities associated with inadequate nutrition and early learning opportunities can undermine children's health and development, thereby compromising their productivity and societal contributions* (ibid, p.1). Haselow et al., 2016 investigate a nutrition program in Asia (Enhanced Homestead food production program) present the evidence for a alarming problem with stunting children '*The largest percentage (56%) and number of stunted children (96 million) live in Asia* (UNICEF et al. 2012 in Haselow et al., 2016, p. 156). According to Rivera et al., 2004 the problem of child malnutrition in developing countries influenced about 150 million children in total which is more than '*one quarter of all children younger than 5 years'* (ibid, p. 2563). In addition, the authors consider that large scale program would not provide control conditions as the small one and the impact on child nutrition and survival could be less.

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The analysis of the data shows that for developing and middle-income countries, the key problem is food provision, and this affects a significant part of children, living in families, who experience food insecurity. In the developing countries, the problem relates to the possibility to ensure healthy food and presence inappropriate feeding practices.

Problem solutions

The **problem solutions** are oriented towards four main areas:

- nutritional - food packages, which could be vouchers, packages, or money;
- educational – development of knowledge and skills;
- programs containing different components – nutritional and educational;
- integrated programs/nutritional specific and nutritional sensitive programs.

Some of the programs, containing **different components,** provide food packages or financial resources. One of these programs is '**Women, Infants and Children' (WIC)**[40]**,** which provides nutrition education and food packages for individual participants and referral for health services (Black et al., 2004; Ng et al., 2018). The program targets low-income pregnant,

Women, Infants and Children

The program Women, Infants and Children (WIC) **aims to** safeguard the health of **low-income women**, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to healthcare. WIC is a **public health nutrition program** under the jurisdiction of the United States Department of Agriculture (USDA) **operating since 1972.** The program **targets** low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and infants and children up to age of five who are found to be at nutritional risk. **To enrol**, they contact the regional agency. WIC provides nutrition education and food packages for individual participants and referral for health services. WIC **reduces premature births**, low birth-weight babies, fetal and infant deaths, the incidence of low-iron anemia; it increases access to prenatal care earlier in pregnancy, pregnant women's consumption of key nutrients, as well as increases immunization rates and ensures access to regular healthcare.

[40] https://www.fns.usda.gov/wic

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breastfeeding, and non-breastfeeding postpartum women, and infants and children up to age of five who are found to be at nutritional risk.

The **Program 'Progresa'[41] in Mexico** provides nutrition education, health care, and cash transfers, as well as fortified nutrition supplements to children, pregnant and lactating women in participating households. (Rivera et al., 2004).

In another article, a **solely nutritional** voucher program for pregnant women and infants is described – **Healthy Start[42]**. It is a statutory means-tested food voucher programme that was introduced across the UK in 2006. Those registered for Healthy Start receive vouchers, which can be exchanged for fresh or frozen fruit and vegetables, plain cows' milk or infant formula, and coupons for free

Progresa

The program **is targeted** to the poor and it involves co-responsibility by beneficiaries, and promotes long-term behavioral change. The program **is targeted** to the poor and it involves co-responsibility by beneficiaries and promotes long-term behavioral change. The program is **state funded since 1997**. Now it is operating as the state assistance program Prospera. Progresa provides cash transfers to poor rural households, **on condition that** their children attend school and their family visits local health centers regularly. According to the evidence base, consumption, mostly food intake, has increased by 22%; the proportion of malnourished children has decreased; enrolment in secondary school has increased; regular health visits among young children have increased; increased prenatal care visits, etc.

Healthy Start UK

The aim of the Healthy Start (HS) program is to improve the diet of pregnant and children under 4. HS is **state funded and still operating** in UK **since 2006**. Pregnant and mothers of a child under 4 who received income support for young mothers under 18 **must fill the application** and send it to the agency which check the data. **The program includes** provision of free vouchers every week for milk, fresh, frozen, and tinned fruit and vegetables, fresh, dried, and tinned pulses, and infant formula milk and free vitamins. The clients can spend the vouchers in the fixed retails shops. **HS increases the quantity** and range of fruit and vegetables the families use and improves the quality of their diets, as well as establishes good habits for the future.

[41] https://www.povertyactionlab.org/evaluation/impact-progresa-health-mexico
[42] https://www.healthystart.nhs.uk/

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vitamin supplements (McFadden, 2014).

The third group, as mentioned, are **solely educational programs**. These programs focus on teaching caregivers appropriate complementary feeding and strategies for how to feed and play responsively through home-visits, which would increase children's dietary intake, growth and development compared with home-visit-complementary feeding education alone or routine care (Vazir et al., 2012).

The last group are **integrated programs**/nutritional specific and nutritional sensitive programs, which integrate ECD with health and nutrition services and include nutrition specific and sensitives interventions. Such a program is the Integrated Community Development Program (ICDP). The program includes a range of center-based health, hygiene, and educational activities. 'The primary aim of ICDP is to promote immunization, anemia prevention, use of safe drinking water, hand washing and sanitation, and ECCE activities in small communities.' (Jahan, 2005 in Hamadani, 2014).

Another program is an integrated nutrition-sensitive and nutrition-specific program, such as Hellen Keller International's (HKI) Enhanced Homestead Food Production[43], which can impact stunting by addressing its underlying determinants, including supporting optimal nutrition, care and health practices among disadvantaged

Hellen Keller International's Enhanced Homestead Food Production

The program **aims to** improve maternal and child health and nutrition outcomes through the following pathways: increasing the availability of micronutrient-rich foods through increased household production of these foods; raising income through the sale of surplus production; increasing knowledge and adoption of optimal nutrition practices, including the consumption of micronutrient-rich foods. The program is **privately funded** by Heller Keller International and **governmental support**. It **has been operating** for 20 years in Asia and Africa. **The program integrates** good agricultural practices, training, education about nutrition and hygiene, and women's empowerment. The activities can vary, depending on the region. The program **has proven effect** on maternal and child health and household hygiene.

[43] https://www.ifpri.org/project/hki-homestead-food-production-programs

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women of reproductive age and infants and young children, reducing food insecurity, empowering women and improving water, sanitation and hygiene' (Haselow at al., 2016).

In addition, the 'Lady, health, worker' (LHW) program selects community women to assist in family health initiatives. Their main tasks are to maintain records of all married couples, pregnant women, births and deaths, offer family planning advice, distribute contraceptives, provide care for pregnant women, health and hygiene education, basic child nutrition education, monitor child growth; provide education about Malaria, HIV/AIDS, and TB, and make referrals to primary healthcare 'facilities (Hafeez et al. 2011, in Govani et al., 2014).

Conceptual framework

The **conceptual framework**, used in the articles, consists of basic concepts for child nutrition, used in the area, which are defined above in the report, in order to clarify both the researchers' findings and to support the understanding for stockholders (see p. 2 to p. 9)

Study design and methodology. Findings

The **study design and methodology** are presented in a different way in the different articles, related to the purpose and conceptual framework. Only in two articles, a qualitative methodology is used, such as interviews and focus groups. This means that attitudes and changes in the behaviour are less researched in comparison with impact and effects. The qualitative methods are desk review, interviews, and focus groups, and they are used mostly for feedback and formative assessment to assess the relevance and take decisions if it is necessary to change some aspect of the programs.

There are also studies, using the mixed-methods approach, including experimental designs such as randomised controlled trials, which allows to see the difference between children and families, included in the program, and those who are not participants. There is an article reviewing the cost effectiveness of a program.

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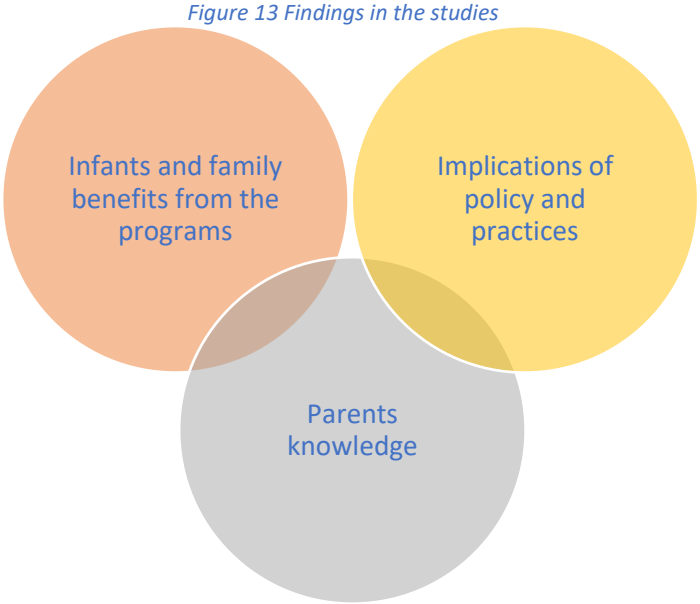
In most of the research projects conducted, quantitative methods are used, since in general in countries, such as the USA, this is considered a valid approach, providing possibility for a bigger scope of the study. Some of the studies are longitudinal, in order to see what the impact of the program is in the long-term, regarding children's development. Some of the studies have an experimental design, while others have a quasi-experimental design. The methods are mainly surveying, secondary data analysis. Four articles are reviews of policies and practices, which consists of examples of quantitative research.

The **main findings** are related to different aspects of the effects and impact of the programs on child development. Evidence strongly suggests that the earlier children are exposed to integrated nutrition and child development interventions, the stronger the cognitive benefit will be. As Black points in his review article even children live in bad circumstances with adequate nutrition, caregiving and learning they can develop their potential. The author emphases that „Nurturing environment; beneficial effects on cognitive development and academic achievement have been demonstrated in multiple studies, showing that sensitivity to child development interventions extends through the second 1000 d and into the school-age years. (Black et al., 2015). The findings can be grouped in the following way, shown on figure 13.

Figure 13 Findings in the studies



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One of the most significant findings is about infant and family benefits. In an experimental study Ng. compare participating versus nonparticipating in the WIC program find out that the program improved nutritional profiles of food purchases for participating households. 'Nutrition improvements highlight how updating policies can meaningfully influence not just WIC participants themselves, but also their families, given changes in household purchases' (Ng et al., 2018, p.7).

In a randomized effectiveness study, Rivera et al. (2004) study the Mexican nutritional program Progresa, which is a large-scale, incentive-based development program with a nutritional intervention. The program is associated with better growth and lower rates of anaemia in low-income, rural infants and children in Mexico. 'Progresa was associated with better growth in height among the poorest and younger infants' (Rivera et al., 2004, p.2563).

The findings also give information about the effect on child development and health of the infants, participating in the program in comparison with non-participants. 'Among infants, 12 months of age, who were eligible for WIC, those who did not receive WIC assistance because of access problems were more likely to be underweight, short, and perceived as having health problems, compared with WIC assistance recipients, even after adjustment for demographic factors, breastfeeding, and birth weight' (Black et al., 2004, p. 173).

Findings shows that *parent's knowledge* and improved skills have a direct effect on child development and health. In a study of a program in India, Vazir et al. (2012) compare families participating and non-participating in activities for complementary feeding and play activities with children find out that 'it is important to educate mothers/caregivers on age and culture-appropriate complementary foods, because this improves infant and toddler growth. 'Responsive complementary feeding educational intervention and skills to stimulate infants through play to mothers/caregivers improves toddler developmental outcomes' (ibid, p. 100).

In addition, in some of review the articles, such as the one of Black et al., it is pointed out that advances in brain science have documented that the origins of adult health and well-being are grounded in early childhood, from conception through age 24 months and extending to age 5.

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Evidence from adoption, experimental, and quasi experimental studies has shown that stunting prevention is sensitive during the first 1000 days, and sensitivity to child development interventions extends through the second 1000 days (Black et al., 2015).

Some of the findings prove that the programmes resulted in development and changes in parents' knowledge and improvement of their health. In a qualitative research parents of Lovelance et al. participant are interviewed about their knowledge, habits for child feeding and access to food. 'Parents overwhelmingly wanted to act in the best interests of their children, but this was sometimes limited by lack of knowledge or cooking skills, although parents may have not recognised that. By improving the diets of children, parents' diets also benefitted' (Lovelace & Rabiee-Khan**,** 2015, p. 9).

Other programs are related to the attendance of educational programs, such as cooking classes and provision of health food for low-income pregnant women and mothers of children. Watt et al. analyse the data about infant maternal health support and feeding practices of Spanish low-income mothers and compare with women who do not have access to WIC program. The authors **pointed out** that women participating in nutritional program 'have significant improvements in diet, exercise, and depressions, they are more likely to breastfeed' and they are 'more likely to pass the ages and stages developmental screening' (Watt et all,2015, p. 537).

In addition, Gosliner & Shah (2020), in their qualitative research, state that participants 'experience multiple challenges, primarily inadequate income and limited access to high quality, affordable healthy food contrasted with easy access to affordable unhealthy food. Despite efforts to manage food resources, most struggle to afford adequate diets. Employed parents confront a particularly challenging dual poverty of money and time. Many parents report feeling guilt related to feeding their children. Participants appreciate available programs and services and suggest increasing community input; providing sustainable programs; lowering the cost of and improving access to healthy food; reducing access to unhealthy food; modifying food assistance efforts; and improving nutrition education and promotion.' Responsible feeding and appropriate practices are connected not only with parents' knowledge, but with their financial 'inadequate

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income and limited access to high quality, affordable healthy food contrasted with easy access to affordable unhealthy food' (ibid, p. 407). Limited income greatly constrains families' diets, and when combined with limited time, leaves people with few options but to feed their children inexpensive, highly processed foods and fewer healthy foods, increasing their chronic disease risk. (ibid).

Moreover, there are findings that some of the research has *implications on policy and practice*. For example, Lui & Stein emphases in their review article that such a program has established national dietary guidelines that are specific for children and easily understood and applied by parents, as well as promoted and supported breastfeeding with the goal to increase the proportion of mothers who breastfeed to 75% in the early postpartum period, 50% at six months and 25% at one year. Another implication on policy and practice is an increase in the availability of affordable fresh foods, especially fruit and vegetables, in low socio-economic communities' (Liu & Stein, 2012, p. 4).

Another longitude study follows a cohort of infants until the age of 7 and indicates that, 'in an industrialised society, exclusive breast feeding for at least 15 weeks and the avoidance of solid foods before 15 weeks in healthy term infants may confer significant long-term health benefits on the child. These data provide clinical evidence to support the current national recommendations for breastfeeding and timing of introduction of solid foods' (Wilson et al 1998).

Some of the findings relate to cost effectiveness and cost benefit of the programs, combining responsible stimulation and nutrition. In cost-effectiveness analysis of a program in Pakistan Govani et al. found that 'At 12 and 24 months, children who received RS interventions performed significantly better. The analysis suggests that, with further refinement, integrating early stimulation with nutrition support can be scaled-up effectively; on the basis of existing data in other settings, the cost–benefit to the country could be very significant'. (Govani et al., 2014 in Black et al., 2015). What's more, investments in intervention programs early in life are more cost effective than investments during later years'. (Heckman, 2006 in Black & Dewey, 2014).

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Recommendations in the articles

The recommendations in the analysed studies vary in terms of scope. Firstly, some of the recommendations concern the duration of the program and ongoing support for the families. (Barnett in Black, & Dewey, 2014)

Secondly, in some of the articles improvement of the programs is recommended, concerning access, process of delivery, raising awareness, etc. For example, Healthy Start vouchers needs to be simplified. Nationally, an awareness raising campaign in relation to Healthy Start vitamins is needed and the process for claiming. The complexity of the health promotion messages needs to be translated into useful everyday menus for parents by people who understand parents' food preferences (Lovelace, S., & Rabiee-Khan, F., 2015). 'Waiting lists and logistic barriers to WIC participation should be eliminated, to ensure adequate growth and health of our nation's low-income infants' (Black et al., 2004). 'Responsive feeding is very important in dietary habit formation and should be encouraged by health professionals in their advice to families' (Silva et all, 2016, p.1). In addition, children require adequate nutrition, along with nurturant care and early learning (Black et al., 2015). Improvement of the programs content is necessary, to make them closer to the culture of families.

Other recommendations are related to the Policy level and effective partnership. All sectors, public and private, need to form effective partnerships and do their part to deliver quality services to disadvantaged populations. Closing the stunting gap requires a mix of interventions based on evidence-based solutions. Long-term exposure to disadvantaged communities and household (Stormer, A., & Pries, A. 2016). The implementation of effective early child development programs requires strong intersectoral coordination. 'More work is needed to design an integrated nutrition specific and nutrition-sensitive strategy that intensifies the current known solutions, improves targeting and/or includes additional interventions that may leverage impact on stunting. This will also require that all sectors, public and private, form effective partnerships and do their part to deliver quality services to disadvantaged communities and households.' (Haselow et al, 2016, p.155).

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In addition, more research is necessary on the cost effectiveness of the program. Policy decisions regarding expenditure of limited public funds require the development of quality information on the cost–benefit and cost effectiveness of interventions (Govani et al., 2014).

In summary, integrated programs with a nurturing component have been identified. This means that, apart from food vouchers or other forms of nutritional support, development of parental skills for food preparation, high quality food consumption, etc., for instance, are also components of these programs. In general, in some of the articles improvement of the programs is recommended, concerning access, process of delivery, raising awareness, etc. Other recommendations are related to the policy level and effective partnership. All sectors, public and private, need to form effective partnerships and do their part to deliver quality services to disadvantaged populations. Additionally, more research is necessary on the cost effectiveness of the program.

6. Conclusions and recommendations

This research has identified many studies, related to different components of the ECD policies: good health, adequate nutrition, security and safety, opportunities for early learning and secure and safe environment for the child's development. Among them are research-based and review articles, in which with a different methodology, are presented findings regarding programs and policies, oriented towards these key areas.

The identified studies are partially related to the identified practices in the I part of the research, which could be explained by the fact that some of the identified practices in the I part have not been studied purposefully, as well as by the possibility to extend and upgrade the provided information from the I report.

All of the analysed articles, published in renowned scientific journals, provide information regarding different components of the quality of the programs, among which are mostly studies of the effectiveness and impact, as well as availability and accessibility.

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The articles use different sources of information, data collection with qualitative and quantitative methods, as well as monitoring data, collected through the implementation of the programs, secondary data analysis and desk review. Most of the articles have specific policy recommendations. The programs in these articles have rendered significant positive change through the robust evaluation.

On figure 14 is provided summarised information from the I and II part of the research, related to evidence-based practices in countries with a similar socioeconomic profile and from research and review articles, as well as policy recommendations, which could be applied to the Bulgarian context.

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Figure 14 Conclusions and recommendations

Access to healthcare services of children aged to 3, pregnant women and mothers:

- Identified evidence-based practices in countries with a similar socioeconomic profile show that access to prenatal care is ensured for all pregnant women; visits at the homes of families with new-borns happen usually as a part of HV services

- Identified solutions in the research articles show that the evidence base confirms that equal access is ensured since it is a national priority. Various practices have been identified, which are successfully implemented, depending on the national context, and include the involvement of paraprofessionals or trained people from the community.

- Change in the legislation to ensure equal access to prenatal care for all pregnant women
- Creation of a national HV system of services

Services in support of opportunities for early learning and responsive caregiving:

- Identified evidence-based practices in countries with a similar socioeconomic profile show that there is a big variety of HV services - universal, as well as targeted towards vulnerable communities; early learning services are usually integrated and a part of group and individual programs

- Identified solutions in the research articles show that the evidence base confirms the effectiveness of the HV programs and those for early learning

- A HV system should be developed and implemented. It should have different components - universal and targeted.
- A methodology of the service should be developed, including different components, among which early learning should be central

Access to services in support of secure and safe environments for children's development:

- Identified evidence-based practices in countries with a similar socioeconomic profile show that practices are specific and related to solving concrete problems of vulnerable groups without personal documents; a universal program for development of parental skills has also been identified

- Identified solutions in the research articles show that the problem with undocumented people is viewed in terms of different solutions for health system access and statelessness; there is a variety of highly effective positive parenting programs

- There needs to be a change in the legislation in terms of access of undocumented people to health and other services
- Development and implementation of programs for positive parenting in different forms

ECD services in support of adequate nutrition of the pregnant women, breastfeeding women, and young children, living below the poverty line:

- Identified evidence-based practices in countries with a similar socioeconomic profile show that practices are integrated, they include food provision and development of parental skills for feeding, high quality food, etc.

- Identified solutions in the research articles show that there needs to be such services, but they depend on the local context and poverty

- Development of a program, which combines nutritional support and development of parenting skills. The loval context needs to be taken into account when developing this program.

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7. Annex 1 Coding trees

Figure 15 Example coding tree for Home visiting problem solutions

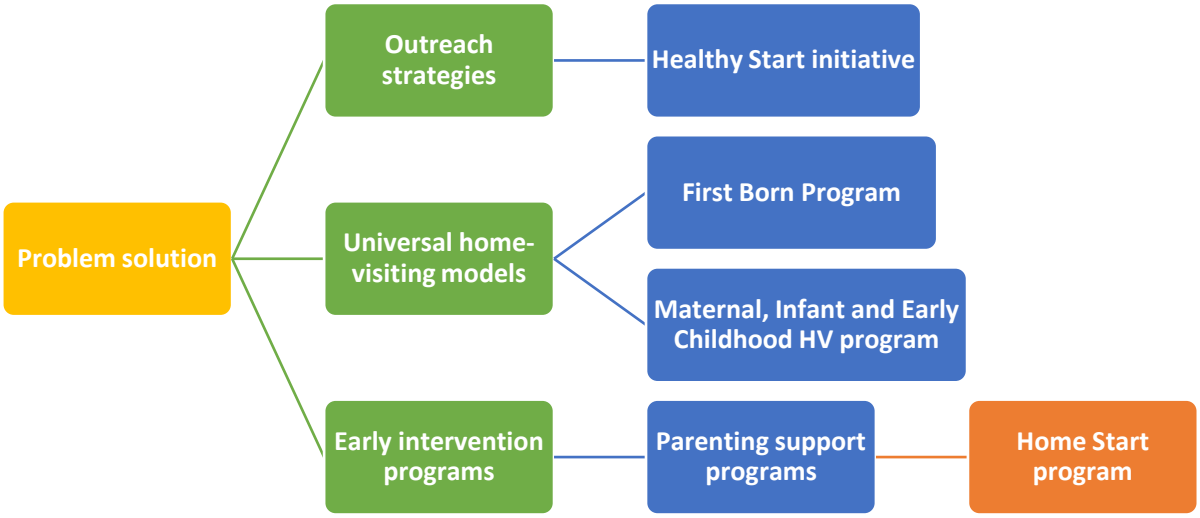
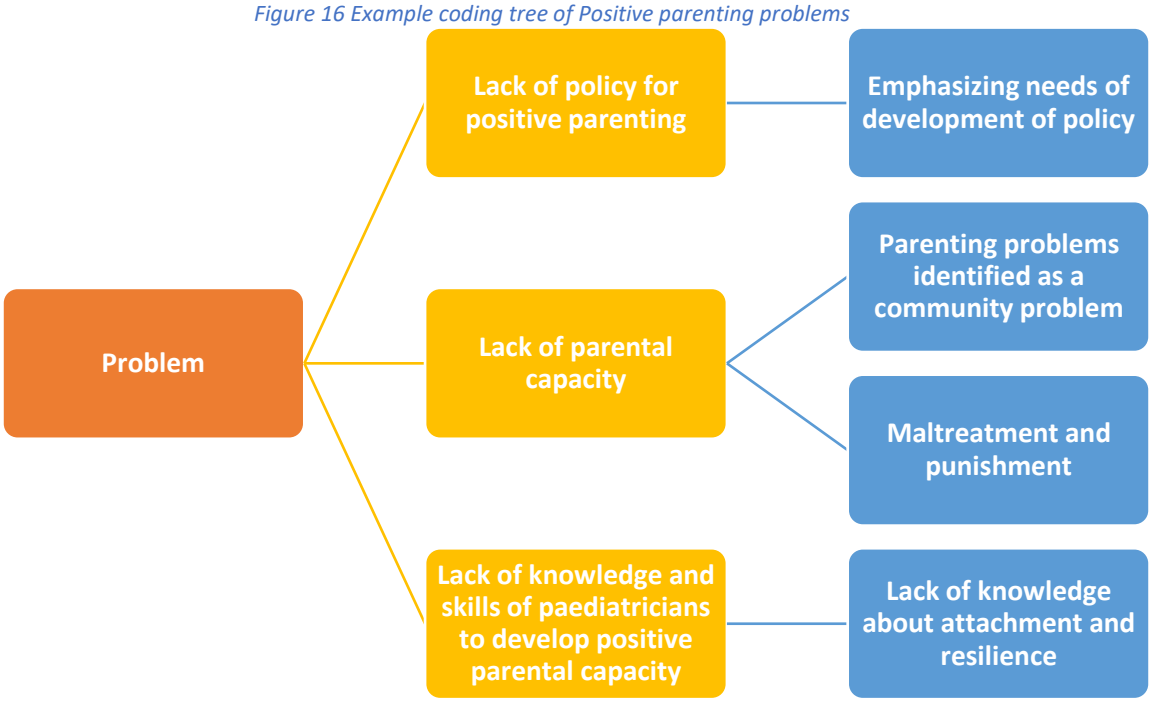


Figure 16 Example coding tree of Positive parenting problems



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Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

8. References

- Asscher, J. J., Hermanns, J. M., & Deković, M. (2008). Effectiveness of the Home-Start parenting support program: Behavioral outcomes for parents and children. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, *29*(2), 95-113 Retrieved from: https://www.home-start.nl/documenten/Onderzoek%20publicaties%20artikelen/2008%20Effectiveness%20of%20the%20Home-Start%20program.pdf
- Belsky, J., Melhuish, E., & Barnes, J. (2008). Research and policy in developing an early years' initiative: the case of Sure Start. International Journal of Child Care and Education Policy, 2(2), 1-13.
- Black, M. M., Cutts, D. B., Frank, D. A., Geppert, J., Skalicky, A., Levenson, S., ... & Meyers, A. F. (2004). Special Supplemental Nutrition Program for Women, Infants, and Children participation and infants' growth and health: a multisite surveillance study. Pediatrics, 114(1), 169-176.
- Black, M. M., & Dewey, K. G. (2014). Promoting equity through integrated early child development and nutrition interventions. Annals of the New York Academy of Sciences, 1308(1), 1-10.
- Black, M. M., Pérez-Escamilla, R., & Fernandez Rao, S. (2015). Integrating nutrition and child development interventions: scientific basis, evidence of impact, and implementation considerations. Advances in Nutrition, 6(6), 852-859.
- Black, M. M., Walker, S. P., Fernald, L. C., Andersen, C. T., DiGirolamo, A. M., Lu, C., ... & Lancet Early Childhood Development Series Steering Committee. (2017). Advancing Early Childhood Development: From Science to Scale 1: Early childhood development coming of age: Science through the life course. Lancet (London, England), 389(10064), 77.
- Burger, S. (2010). A cost consequence analysis of outreach strategies for high risk pregnant women. Journal of community health nursing, 27(3), 137-145. Retrieved from: https://www.jstor.org/stable/20750836?seq=1#metadata_info_tab_contents

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

- Cortellesi, G., & Kernan, M. (2016). Together old and young: How informal contact between young children and older people can lead to intergenerational solidarity. Studia pedagogica, 21(2), 101-116.
- Cho, J., Bae, D., Terris, D. D., Glisson, R. E., & Brown, A. (2018). Community contextual effects on at-risk mothers' engagement in Georgia's Maternal, Infant, and Early Childhood Home Visiting programme. Child & Family Social Work, 23(4), 590-598. Retrieved from (abstract only): https://onlinelibrary.wiley.com/doi/abs/10.1111/cfs.12448
- Dodge, K. A., Goodman, W. B., Bai, Y., O'Donnell, K., & Murphy, R. A. (2019). Effect of a Community Agency–Administered Nurse Home Visitation Program on Program Use and Maternal and Infant Health Outcomes: A Randomized Clinical Trial. JAMA network open, 2(11), e1914522-e1914522. Retrieved from: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2753795
- Dos Santos, S. L. S. (2015). Undeserving mothers? Shifting rationalities in the maternal healthcare of undocumented Nicaraguan migrants in Costa Rica. Anthropology & medicine, 22(2), 191-201.
- Durrant, J., Plateau, D. P., Ateah, C. A., Holden, G. W., Barker, L. A., Stewart-Tufescu, A., & Ahmed, R. (2017). Parents' views of the relevance of a violence prevention program in high, medium, and low human development contexts. International Journal of Behavioural Development, 41(4), 523-531. Retrieved from: https://journals.sagepub.com/doi/abs/10.1177/0165025416687415 (abstract only)
- European Commission (2019). Early Childhood Education and Care. Document available at: https://ec.europa.eu/education/policies/early-childhood-education-and-care_en
- European Commission, (2014) DG for Education and Culture. Proposal for key principles of a Quality Framework for Early Childhood Education and Care Document available at: https://ec.europa.eu/assets/eac/education/policy/strategic-framework/archive/documents/ecec-quality-framework_en.pdf
- Finnerty, F., George, S., & Eziefula, A. C. (2018). The health of recent migrants from resource-poor countries. Medicine, 46(1), 66-71.

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

- ISSA (2016), Quality Framework for Early Childhood Practice in Services for Children under Three Years of age, 2016. Document available at: https://www.issa.nl/quality_framework_birth_to_three
- Gosliner, W., & Shah, H. (2020). Participant voices: examining issue, program, and policy priorities of SNAP-Ed eligible adults in California. Renewable Agriculture and Food Systems, 35(4), 407-415.
- Gowani, S., Yousafzai, A. K., Armstrong, R., & Bhutta, Z. A. (2014). Cost effectiveness of responsive stimulation and nutrition interventions on early child development outcomes in Pakistan. Annals of the New York Academy of Sciences, 1308(1), 149-161
- Hahlweg, K., Heinrichs, N., Kuschel, A., Bertram, H., & Naumann, S. (2010). Long-term outcome of a randomized controlled universal prevention trial through a positive parenting program: is it worth the effort?. Child and adolescent psychiatry and mental health, 4(1), 14. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/20470435/ (summary only)
- Haselow, N. J., Stormer, A., & Pries, A. (2016). Evidence-based evolution of an integrated nutrition-focused agriculture approach to address the underlying determinants of stunting. Maternal & Child Nutrition, 12, 155-168.
- Hornor, G., Quinones, S. G., Boudreaux, D., Bretl, D., Chapman, E., Chiocca, E. M., ... & Morris, K. A. (2020). Building a Safe and Healthy America: Eliminating Corporal Punishment via Positive Parenting. Journal of Paediatric Health Care, 34(2), 136-144. Retrieved from: https://www.researchgate.net/publication/337892543_Building_a_Safe_and_Healthy_America_Eliminating_Corporal_Punishment_via_Positive_Parenting
- Hutchings, J., Bywater, T., Daley, D., Gardner, F., Whitaker, C., Jones, K., ... & Edwards, R. T. (2007). Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial. Bmj, 334(7595), 678.
- Kilburn, M. R., & Cannon, J. S. (2017). Home visiting and use of infant health care: a randomized clinical trial. Paediatrics, 139(1). Retrieved from: https://pubmed.ncbi.nlm.nih.gov/27980028/ (abstract only)

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

- Korfmacher, J., Frese, M., & Gowani, S. (2019). Examining program quality in early childhood home visiting: From infrastructure to relationships. Infant mental health journal, 40(3), 380-394. Retrieved from: https://onlinelibrary.wiley.com/doi/10.1002/imhj.21773 (abstract only)
- Laditka, S. B., Laditka, J. N., & Probst, J. C. (2006). Racial and ethnic disparities in potentially avoidable delivery complications among pregnant Medicaid beneficiaries in South Carolina. Maternal and Child Health Journal, 10(4), 339-350.
- Long, S. H., & Marquis, M. S. (1998). The effects of Florida's Medicaid eligibility expansion for pregnant women. American Journal of Public Health, 88(3), 371-376.
- Lanier, P., Maguire-Jack, K., & Welch, H. (2015). A nationally representative study of early childhood home visiting service
- Liu, Y. H., & Stein, M. T. (2012). Feeding behaviour of infants and young children and its impact on child psychosocial and emotional development. Encyclopaedia on early childhood development. Montreal: Centre of Excellence for Early Childhood Development and Strategic Knowledge Cluster on Early Child Development.
- Love, J. M., Kisker, E. E., Ross, C., Raikes, H., Constantine, J., Boller, K., ... & Fuligni, A. S. (2005). The effectiveness of early head start for 3-year-old children and their parents: lessons for policy and programs. Developmental psychology, 41(6), 885
- Lovelace, S., & Rabiee-Khan, F. (2015). Food choices made by low-income households when feeding their pre-school children: a qualitative study. Maternal & child nutrition, 11(4), 870-881.
- Lori, J. R., Perosky, J., Munro-Kramer, M. L., Veliz, P., Musonda, G., Kaunda, J., ... & Scott, N. (2019). Maternity waiting homes as part of a comprehensive approach to maternal and newborn care: a cross-sectional survey. BMC pregnancy and childbirth, 19(1), 228.
- Lucas, J. E., Richter, L. M., & Daelmans, B. (2018). Care for Child Development: an intervention in support of responsive caregiving and early child development. Child: Care, health and development, 44(1), 41-49. Retrieved from: https://bit.ly/3p1oRnj

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

- Leppälä, S., Lamminpää, R., Gissler, M., & Vehviläinen-Julkunen, K. (2020). Humanitarian migrant women's experiences of maternity care in Nordic countries: A systematic integrative review of qualitative research. Midwifery, 80, 102572.
- Maldonado, L. Y., Songok, J. J., Snelgrove, J. W., Ochieng, C. B., Chelagat, S., Ikemeri, J. E., & Christoffersen-Deb, A. (2020). Promoting positive maternal, new-born, and child health behaviours through a group-based health education and microfinance program: a prospective matched cohort study in western Kenya. BMC Pregnancy and Childbirth, 20, 1-14.
- Manby, B. (2020)., The Sustainable Development Goals and 'legal identity for all': 'First, do no harm'. World development 139 (2021) https://doi.org/10.1016/j.worlddev.2020.105343 (abstract)
- Melhuish, E., Belsky, J., Leyland, A. H., Barnes, J., & National Evaluation of Sure Start Research Team. (2008). Effects of fully-established Sure Start Local Programmes on 3-year-old children and their families living in England: a quasi-experimental observational study. The Lancet, 372(9650), 1641-1647
- Melhuish, E., Ereky-Stevens, K., Petrogiannis, K., Ariescu, A., Penderi, E., Rentzou, K., ... & Leseman, P. (2015). A review of research on the effects of Early Childhood Education and Care (ECEC) upon child development.
- McBride, S. L., & Peterson, C. (1997). Home-Based Early Intervention with Families of Children with Disabilities: Who is Doing What? Topics in Early Childhood Special Education, 17(2), 209-233. Retrieved from: https://journals.sagepub.com/doi/10.1177/027112149701700206 (abstract only)
- McFadden, A., Green, J. M., Williams, V., McLeish, J., McCormick, F., Fox-Rushby, J., & Renfrew, M. J. (2014). Can food vouchers improve nutrition and reduce health inequalities in low-income mothers and young children: a multi-method evaluation of the experiences of beneficiaries and practitioners of the Healthy Start programme in England. BMC public health, 14(1), 1-13.

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

- Miró, R. Á., Canut, M. L., Aloy, J. F., Ruiz, M. E., Gili, L. A., Rodríguez, J. B., & Estrany, X. C. (2014). Influence of in-home nursing care on the weight of the early discharged preterm newborn. Anales de Pediatría (English Edition), 81(6), 352-359.
- Morrison, J., Pikhart, H., & Goldblatt, P. (2017). Interventions to reduce inequalities in health and early child development in Europe from a qualitative perspective. International journal for equity in health, 16(1), 87.
- Ng, S. W., Hollingsworth, B. A., Busey, E. A., Wandell, J. L., Miles, D. R., & Poti, J. M. (2018). Federal nutrition program revisions impact low-income households' food purchases. American journal of preventive medicine, 54(3), 403-412.
- O'Connor, P. (2001). Supporting mothers: Issues in a community mothers programme. Community, Work & Family, 4(1), 63-85.
- Petr, C. G. (2003). Social work with children and their families: Pragmatic foundations. Oxford university press.
- Phillimore, J. (2016). Migrant maternity in an era of superdiversity: new migrants' access to, and experience of, antenatal care in the West Midlands, UK. Social Science & Medicine, 148, 152-159.
- Pineda, R., Heiny, E., Nellis, P., Smith, J., McGrath, J. M., Collins, M., & Barker, A. (2020). The Baby Bridge program: A sustainable program that can improve therapy service delivery for preterm infants following NICU discharge. Plos one, 15(5), e0233411.
- Piper, J. M., Mitchel Jr, E. F., & Ray, W. (1994). Presumptive eligibility for pregnant Medicaid enrolees: its effects on prenatal care and perinatal outcome. American journal of public health, 84(10), 1626-1630.
- Prado, E. L., & Dewey, K. G. (2014). Nutrition and brain development in early life. Nutrition reviews, 72(4), 267-28
- Ramey, C. T., Campbell, F. A., Burchinal, M., Skinner, M. L., Gardner, D. M., & Ramey, S. L. (2000). Persistent effects of early childhood education on high-risk children and their mothers. Applied developmental science, 4(1), 2-14

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

- Rittenhouse, D. R., Braveman, P., & Marchi, K. (2003). Improvements in prenatal insurance coverage and utilization of care in California: an unsung public health victory. Maternal and child health journal, 7(2), 75-86.
- Roisne´, J., Delattre, M., Rousseau, S., Bourlet, A., Charkaluk, M.-L. (2018). Newborn follow-up after discharge from the maternity unit: Compliance with national guidelines, Archives de Pediatrie, 25, 95–99
- Rowland, D., Salganicoff, A., & Keenan, P. S. (1999). The key to the door: Medicaid's role in improving health care for women and children. Annual Review of Public Health, 20(1), 403-426.
- Rodrigo, M. J. (2010). Promoting positive parenting in Europe: New challenges for the European Society for Developmental Psychology. European Journal of Developmental Psychology, 7(3), 281-294. Retrieved from: https://www.tandfonline.com/doi/abs/10.1080/17405621003780200
- Rivera, J. A., Sotres-Alvarez, D., Habicht, J. P., Shamah, T., & Villalpando, S. (2004). Impact of the Mexican program for education, health, and nutrition (Progressa) on rates of growth and anaemia in infants and young children: a randomized effectiveness study. Jama, 291(21), 2563-2570.
- Sackett, D.L, Rosenberg, W.M.C., Muir Gray, J.A., Haynes, R.B., & Richardson, W.S. (1996). Evidence-based medicine: What it is and what it isn't. British Medical Journal, 312(7023), 71-72
- Sanders, M. R., Cann, W., & Markie-Dadds, C. (2003). The Triple P-Positive Parenting Programme: a universal population-level approach to the prevention of child abuse. Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect, 12(3), 155-171. Retrieved from: https://onlinelibrary.wiley.com/doi/abs/10.1002/car.798 (abstract only)
- Silva, G. A., Costa, K. A., & Giugliani, E. R. (2016). Infant feeding: beyond the nutritional aspects. Jornal de pediatria, 92(3), 2-7.

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

- Silva, R. M. M. D., Zilly, A., Nonose, E. R. D. S., Fonseca, L. M. M., & Mello, D. F. D. (2020). Care opportunities for premature infants: home visits and telephone support. Revista Latino-Americana de Enfermagem, 28.
- Sitrin, D., Guenther, T., Waiswa, P., Namutamba, S., Namazzi, G., Sharma, S., & Chimbalanga, E. (2015). Improving new-born care practices through home visits: lessons from Malawi, Nepal, Bangladesh, and Uganda. Global health action, 8(1), 23963.
- Shah, R., Kennedy, S., Clark, M. D., Bauer, S. C., & Schwartz, A. (2016). Primary care–based interventions to promote positive parenting behaviours: A meta-analysis. Pediatrics, 137(5). Retrieved from: https://pediatrics.aappublications.org/content/137/5/e20153393
- Shan, W., Zhang, Y., Zhao, J., Zhang, Y., Cheung, E. F., Chan, R. C., & Jiang, F. (2019). Association between Maltreatment, Positive Parent–Child Interaction, and Psychosocial Well-Being in Young Children. The Journal of paediatrics, 213, 180-186. Retrieved from: https://www.researchgate.net/publication/335078059_Association_between_Maltreatment_Positive_Parent-Child_Interaction_and_Psychosocial_Well-Being_in_Young_Children (abstract only)
- Svendsen, S., Griffin, J., & Forkey, H. (2020). Using the Attachment Relationship and Positive Parenting Principles to Build Childhood Resilience. Advances in Pediatrics, 67, 15-28.
- Tesfau, Y. B., Kahsay, A. B., Gebrehiwot, T. G., Medhanyie, A. A., & Godefay, H. (2020). Postnatal home visits by health extension workers in rural areas of Ethiopia: a cross-sectional study design. BMC Pregnancy and Childbirth, 20, 1-9.
- Vanessa, G., Cynthia, M., Chiara, Q., & Nina, S. (2019). Temporalities of emergency: Migrant pregnancy and healthcare networks in Southern European borderlands. Social science & medicine, 222, 11-19.
- Vanthuyne, K., Meloni, F., Ruiz-Casares, M., Rousseau, C., & Ricard-Guay, A. (2013). Health workers' perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or a privilege?. Social science & medicine, 93, 78-85.
- Vazir, S., Engle, P., Balakrishna, N., Griffiths, P. L., Johnson, S. L., Creed-Kanashiro, H., ... & Bentley, M. E. (2012). Cluster-randomized trial on complementary and responsive feeding

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

education to caregivers found improved dietary intake, growth and development among rural Indian toddlersmcn_413 99 117.

- Vázquez Álvarez, N., Molina Garuz, M. C., Ramos, P., & Artazcoz Lazcano, L. (2017). Effectiveness of a parent training program in Spain: Reducing the Southern European evaluation gap. Gaceta Sanitaria, 2017, vol. 33, num. 1, p. 10-16. Retrieved from: https://reader.elsevier.com/reader/sd/pii/S0213911117301711?token=A847AEA61E22596E9538C1E597D47DE9FF687425A4E8B04D6C8536055F16E1D3FF648BEC0505117895741C56BFBF9243

- Wanwong, Y., Nipaporn, S. , Nopparattayaporn, P., Poungkanta, W., Putthasri, W., Suphanchaimat, R. (2017), Health Insurance for Undocumented Migrants: A Literature Review in Developed Countries, Special Article, J Med Assoc Thai Vol. 100 No. 6 , https://www.researchgate.net/publication/318265024_Health_insurance_for_undocumented_migrants_A_literature_review_in_developed_countries (full text)

- Watt, T. T., Appel, L., Lopez, V., Flores, B., & Lawhon, B. (2015). A primary care-based early childhood nutrition intervention: evaluation of a pilot program serving low-income Hispanic women. Journal of racial and ethnic health disparities, 2(4), 537-547

- Weaver, N. L., Weaver, T. L., Loux, T., Jupka, K. A., Lew, D., & Sallee, H. (2019). The impact of RISE Up! in promoting positive parenting and safety behaviours of parents with young children. Children and Youth Services Review, 105, 104422. Retrieved from: https://www.researchgate.net/publication/334577919_The_impact_of_RISE_Up_In_promoting_positive_parenting_and_safety_behaviors_of_parents_with_young_children (abstract only)

- Wilson, A. C., Forsyth, J. S., Greene, S. A., Irvine, L., Hau, C., & Howie, P. W. (1998). Relation of infant diet to childhood health: seven year follow up of cohort of children in Dundee infant feeding study. Bmj, 316(7124), 21-25.

- Wilson, A. N., Spotswood, N., Hayman, G. S., Vogel, J. P., Narasia, J., Elijah, A., ... & Homer, C. S. E. (2020). Improving the quality of maternal and new-born care in the Pacific region: A scoping review. The Lancet Regional Health-Western Pacific, 3, 100028.

Junction Bulgaria Ltd; 122 Cherny vrah Blvd. 1407 Sofia
Tel: +359 (0)2 418 54 86; Mobile: +359 896 875 533; www.junction.bg

- Wendland, A., Ehmsen, B. K., Lenskjold, V., Astrup, B. S., Mohr, M., Williams, C. J., & Cowan, S. A. (2016). Undocumented migrant women in Denmark have inadequate access to pregnancy screening and have a higher prevalence Hepatitis B virus infection compared to documented migrants in Denmark: a prevalence study. BMC Public Health, 16(1), 426.
- Wolff, H., Stalder, H., Epiney, M., Walder, A., Irion, O., & Morabia, A. (2005). Health care and illegality: a survey of undocumented pregnant immigrants in Geneva. Social science & medicine, 60(9), 2149-2154.
- UNICEF (2001 ECD Definition, available at: https://www.unicef.org/sowc01/1-4.htm
- World Bank (2013). What matters most for Early Childhood Development: A Framework Paper, available at: http://wbgfiles.worldbank.org/documents/hdn/ed/saber/supporting_doc/Background/ECD/Framework_SABER-ECD.pdf
- World Health Organization, United Nations Children's Fund, World Bank Group. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO, available at: https://www.who.int/maternal_child_adolescent/child/nurturing-care-framework/en/
- Zarghi, N., & Khorasani, S. D. (2018). Evidence-based social sciences: A new emerging field. European Journal of Social Science Education and Research, 5(2), 207-211. available at: http://journals.euser.org/files/articles/ejser_v5_i2/Zarghi.pdf

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