CHAPTER 5
Equity from the start

"Each one of you is your own person, endowed with rights, worthy of respect and dignity. Each one of you deserves to have the best possible start in life, to complete a basic education of the highest quality, to be allowed to develop your full potential and provided the opportunities for meaningful participation in your communities."

Nelson Mandela and Graça Machel (UNICEF, 2000)

EARLY CHILD DEVELOPMENT AND EDUCATION – POWERFUL EQUALIZERS

Worldwide, 10 million children die each year before their fifth birthday (Black, Morris & Bryce, 2003). The vast majority of these deaths occur among children born in low- or middle-income countries, and within these countries, among children of more disadvantaged households and communities (Houweling, 2007). Even in high-income countries such as the United Kingdom, infant mortality is higher among disadvantaged groups (Department of Health, 2007). There is an urgent need to address these mortality inequities. Equally important, at least 200 million children are not achieving their full developmental potential, with huge implications for their health and for society at large (Grantham-McGregor et al., 2007). The figure of 200 million is certainly an underestimate, as it is based on a definition of poverty at US$ 1/day, whereas there is a stepwise effect of wealth on child development (ECDKN, 2007a). Experiences in early childhood (defined as prenatal development to 8 years of age), and in early and later education, lay critical foundations for the entire lifecourse (ECDKN, 2007a). It is better for the individual child, and for society – in rich and poor countries alike – to provide a positive start, rather than having to resort to remedial action later on. Building on the child survival agenda, governments can make major and sustained improvement in population health and development, while fulfilling their obligations under the UN Convention on the Rights of the Child, by using a more comprehensive approach to the early years of life (ECDKN, 2007a).

A more comprehensive approach to the early years in life

The science of ECD shows that brain development is highly sensitive to external influences in early childhood, starting in utero, with lifelong effects. The conditions to which children are exposed, including the quality of relationships and language environment, literally 'sculpt' the developing brain (Mustard, 2007). Raising healthy children means stimulating their physical, language/cognitive, and social/emotional development (ECDKN, 2007a). Healthy development during the early years provides the essential building blocks that enable people to lead a flourishing life in many domains, including social, emotional, cognitive, and physical well-being (ECDKN, 2007a).

Education, preschool and beyond, also fundamentally shapes children's lifelong trajectories and opportunities for health. Yet despite recent progress, there are an estimated 75 million children of primary-school age not in school (UIS, 2008). Educational attainment is linked to improved health outcomes, partly through its effects on adult income, employment, and living conditions (Ross & Wu, 1995; Cutler & Lleras-Muney, 2006; Bloom, 2007). There are strong intergenerational effects – educational attainment of mothers is a determinant of child health, survival, and educational attainment (Caldwell, 1986; Cleland & Van Ginneken, 1988).

Many challenges in adult society have their roots in the early years of life, including major public health problems such as obesity, heart disease, and mental health problems. Experiences in early childhood are also related to criminality, problems in literacy and numeracy, and economic participation (ECDKN, 2007a).

Social inequities in early life contribute to inequities in health later on, through ECD and educational attainment. Children from disadvantaged backgrounds are more likely to do poorly in school and subsequently, as adults, are more likely have lower incomes and higher fertility rates and be less empowered to provide good health care, nutrition, and stimulation to their own children, thus contributing to the intergenerational transmission of disadvantage (Grantham-McGregor et al., 2007). The seeds of adult gender inequity are also sown in early childhood. Gender socialization and gender biases in the early years of life have impacts on child development, particularly among girls. Early gender inequity, when reinforced by power relations, biased norms, and day-to-day experiences, go on to have a profound impact on adult gender inequity (ECDKN, 2007a).

Much of child survival and development depends on factors discussed in other chapters of this report. In the early years, the health-care system has a pivotal role to play (ECDKN, 2007a). Mothers and children need a continuum of care from pre-pregnancy, through pregnancy and childbirth, to the early days and years of life (WHO, 2005b) (see Chapter 9: *Universal Health Care*). Children need to be registered at birth (see Chapter 16: *The Social Determinants of Health: Monitoring, Research, and Training*). They need safe and healthy environments – good-quality housing, clean water and sanitation facilities, safe neighbourhoods, and protection against violence (see Chapter 6: *Healthy Places Healthy People*). Good nutrition is crucial and begins in utero with adequately nourished mothers, underlining the importance of taking a lifecourse perspective in tackling health inequities (ECDKN, 2007b). It is important to support the initiation of breastfeeding within the first hour of life, skin to skin contact immediately after birth, exclusive breastfeeding in the first 6 months of life, and continued breastfeeding through the second year of life, as is ensuring the availability of and access to healthy diets for infants and young children through improving food security (PPHCKN, 2007a; Black et al., 2008; Victora et al., 2008).

More distally, child survival and development depend on how well and how equitably societies, governments, and international agencies organize their affairs (see Chapters 10

and 14: *Health Equity in All Policies, Systems, and Programmes; Political Empowerment – Inclusion and Voice*). Gender equity, through maternal education, income, and empowerment, plays an important role in child survival and development (see Chapter 13: *Gender Equity*). Children benefit when national governments adopt family-friendly social protection policies that allow an adequate income for all (see Chapter 8: *Social Protection Across the Lifecourse*) and allow parents and caregivers to balance their home and work life (see Chapter 7: *Fair Employment and Decent Work*). Political leaders, nationally and internationally, should play a key role in averting acute threats to the development of young children, including war and violence, child labour, and abuse (WHO, 2005a). Yet global inequities in power influence the ability of poor countries in particular to enact policies that are optimal for child development (ECDKN, 2007a) (see Chapters 11, 12, and 15: *Fair Financing; Market Responsibility; Good Global Governance*).

Children need supporting, nurturing, caring, and responsive living environments. And they need opportunities to explore their world, to play, and to learn how to speak and listen to others. Schools, as part of the environment that contributes to children's development, have a vital role to play in building children's capabilities and, if they are truly inclusive, in achieving health equity. Well-designed ECD programmes can help to smooth the transition of children to primary school, with benefits for subsequent schooling (UNECSO, 2006b).

Creating the conditions for all children to thrive requires coherent policy-making across sectors. Parents and caregivers can do a lot, but support is needed from government, civil society organizations, and the wider community. The neglect of children worldwide has occurred largely in the watch of governments. Civil society organizations therefore have an important role to play in advocating and improving the conditions for healthy child development.

While environments strongly influence ECD, children are social actors who shape, and are shaped by, their environment (ECDKN, 2007b). The appreciation of the relational nature of the child and the environment has implications for action and research, with the need to recognize the importance of giving children greater voice and agency (Landon Pearson Resource Centre for the Study of Childhood and Children's Rights, 2007).

Early child development: a powerful equalizer

Investments in ECD are one of the most powerful that countries can make – in terms of reducing the escalating chronic disease burden in adults, reducing costs for judicial and prison systems, and enabling more children to grow into healthy adults who can make a positive contribution to society, socially and economically (ECDKN, 2007a; Engle et al., 2007; Schweinhart, Barnes & Weikart, 1993; Schweinhart, 2004; Lynch, 2004). Investment in ECD can also be a powerful equalizer, with interventions having the largest effects on the most deprived children (Scott-McDonald, 2002; Young, 2002; Engle et al., 2007). If governments in rich and poor societies were to act while children were young by implementing quality ECD programmes and services as part of their broader development plans, these investments would pay for themselves many times over (Schweinhart, Barnes & Weikart, 1993; Schweinhart, 2004; Lynch, 2004). Unfortunately, most investment calculus in health and other sectors discounts such future benefits and values disproportionately those benefits seen in the immediate to short term.

Reducing health inequities within a generation requires a new way of thinking about child development. An approach is needed that embraces a more comprehensive understanding of the development of young children, including not just physical survival but also social/emotional and language/cognitive development. Recognizing the role of ECD and education offers huge potential to reduce health inequities within a generation. It provides a strong imperative for action early in life, and to act now. Inaction has detrimental effects that can last more than a lifetime.

ACTION TOWARDS A MORE EQUITABLE START IN LIFE

The Commission argues that a comprehensive approach to child development, encompassing not just child survival and physical development but also social/emotional and language/cognitive development, needs to be at the top of the policy agenda. This requires commitment, leadership, and policy coherence at the international and national level. It also requires a comprehensive package of ECD interventions for all children worldwide.

Changing the mindset

The Commission recommends that:

5.1. WHO and UN Children's Fund (UNICEF) set up an interagency mechanism to ensure policy coherence for early child development such that, across agencies, a comprehensive approach to early child development is acted on (see Rec 15.2; 16.8).

The development of young children is influenced by actions across a broad range of sectors, including health, nutrition, education, labour, and water and sanitation. Similarly, many players within and outside the UN system have a bearing on ECD. These include UNDP, Office of the UN High Commissioner for Refugees (UNHCR), UNICEF, UN Population Fund (UNFPA), World Food Programme (WFP), UN Human Settlements Programme (UN-HABITAT), International Labour organization (ILO), the Food and Agriculture Organization of the UN (FAO), UN Educational, Scientific, and Cultural Organization (UNESCO), WHO, Joint UN Programme on HIV/AIDS (UNAIDS), the World Bank, International Monetary Fund (IMF), and International Organization for Migration (IOM), as well as civil society

EQUITY FROM THE START : ACTION AREA 5.1

Commit to and implement a comprehensive approach to early life, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development.

organizations. Many of these agencies do not have improving ECD as an explicit goal, yet they can have an important bearing on it, positively or negatively.

An interagency mechanism should be set up to ensure a comprehensive, coherent approach to ECD. The interagency mechanism can take various forms. A good model is a so-called sub-committee, such as the UN System Standing Committee on Nutrition (SCN) (Box 5.1). Such a committee would bring together not only relevant UN agencies and government actors, but also civil society organizations and professional ECD networks (see Chapter 15: *Good Global Governance*).

Following the SCN model, key activities of the interagency mechanism could include: (i) the development and implementation of a strategy for high-level advocacy and strategic communication, (ii) tracking and reporting on progress towards a healthy start in life for all children, (iii) facilitating the integration of ECD into MDG-related activities at the country level through the UN coordination system, (iv) mainstreaming human rights approaches – in particular, the rights in early childhood as embodied in General Comment 7 on Implementing Child Rights in Early Childhood (UN, 2006a) – into the work of the interagency mechanism, and (v) identifying key scientific and operational gaps (Standing Committee on Nutrition, nd,b). At the country level, the interagency group can promote an approach in which policy makers, practitioners, researchers, and civil society actors form integrated ECD networks to ensure open-access sharing and dissemination of research and practice findings.

Ensuring policy coherence for ECD, nationally and internationally, requires that international organizations, WHO and UNICEF in particular, strengthen their leadership on and institutional commitment to ECD. Within these organizations, many programmes have a bearing on child development, including programmes on child survival, immunization, reproductive health, and HIV/AIDS. ECD should explicitly be taken into account in these programmes. This requires dedicated staff and financing for ECD, in order to:

- play a critical role in advocacy for ECD as a key social determinant of health;
- provide technical support for inclusion of ECD in national-level policies and international development frameworks (such as the Poverty Reduction Strategy Papers [PRSP]);
- provide technical support to regions, countries, and partners for integration of simple ECD interventions (such as Integrated Management of Childhood Illness [IMCI] Care for Development, see Box 5.7) in health services and community health initiatives;
- take responsibility for gathering evidence on the effectiveness of ECD interventions, especially those that are connected to the health-care system;
- support countries in gathering national statistics on and setting up monitoring systems for ECD.

Ensuring a comprehensive approach to ECD requires that international organizations and donors support national governments in building capacity and developing financing mechanisms for implementation of such an approach. A global funding strategy needs to be established to assist countries that are signatories of the Convention of the Rights of the Child to truly implement the UN Committee on the Rights of the Child's General Comment 7, regarding child rights in early childhood.

A comprehensive approach to early childhood in practice

The Commission recommends that:

5.2. Governments build universal coverage of a comprehensive package of quality early child development programmes and services for children, mothers, and other caregivers, regardless of ability to pay (see Rec 9.1; 11.6; 16.1).

An integrated policy framework for early child development

A healthy start for all children is best served by an integrated policy framework for ECD, designed to reach all children. This requires interministerial coordination and policy coherence, with a clear articulation of the roles and responsibilities of each sector and how they will collaborate. Better collaboration between the welfare and education sector, for example, can facilitate the transition from pre-primary programmes to primary education (OECD, 2001). ECD should be integrated into the agendas of each sector to ensure that it is considered routinely in decision-making (see Chapter 10: *Health Equity in all Policies, Systems, and Programmes*).

BOX 5.1: EXAMPLE OF AN INTERAGENCY MECHANISM – THE UN SYSTEM STANDING COMMITTEE ON NUTRITION

The mandate of the SCN is to promote cooperation among UN agencies and partner organizations in support of community, national, regional, and international efforts to end malnutrition in all of its forms in this generation. It will do this by refining the direction, increasing the scale, and strengthening the coherence and impact of actions against malnutrition worldwide. It will also raise awareness of nutrition problems and mobilize commitment to solve them at global, regional, and national levels. The SCN reports to the Chief Executives Board of the UN. The UN members are the Economic Commission for Africa, FAO, International Atomic Energy Agency, International Fund for Agricultural Development, ILO, UN, UNAIDS, UNDP, UN Environment Programme, UNESCO, UNFPA, UNHCR, UNICEF, UN Research Institute for Social Development, UN University, WFP, WHO, and the World Bank. The International Food Policy Research Institute and Asian Development Bank (ADB) are also members. From the outset, representatives of bilateral partners have participated actively in SCN activities, as have nongovernmental organizations (NGOs).

Reproduced, with permission of the UN, from Standing Committee on Nutrition (nd,a).

Implementing a more comprehensive approach to early life includes extending quality interventions for child survival and physical development to incorporate social/emotional and language/cognitive development. ECD programmes and services should comprise, but not be limited to, breastfeeding and nutrition support, comprehensive support to and care of mothers before, during, and after pregnancy – including interventions that help to address prenatal and postnatal maternal mental health problems (Patel et al., 2004) (see Chapter 9: *Universal Health Care*) – parenting and caregiver support, childcare, and early education starting around age 3 (see Action area 2, below) (ECDKN, 2007a). Also, services are needed for children with special needs, including those with mental and physical challenges. Such services include early detection, training caretakers to play and interact with their children at home, community-based early intervention programmes to help children reach their potential, and community education and advocacy to prevent discrimination against children with disabilities (UNICEF, 2000; UNICEF, 2007a). Interventions are most effective when they provide a direct learning experience to the children and their caretakers and are high intensity, high quality, of longer duration, targeted towards younger and disadvantaged children, and built onto established child survival and health programmes to make ECD programmes readily accessible (Engle et al., 2007).

Implementing an integrated policy framework for ECD requires working with civil society organizations, communities, and caregivers. Civil society can advocate and initiate action on ECD, and can be instrumental in organizing strategies at the local level to provide families and children with effective delivery of ECD services, to improve safety and efficacy of residential environments, and to increase the capacity of local and relational communities to better the lives of children (ECDKN, 2007a).

Most countries do not have an integrated policy framework for ECD. At the same time, there are examples of interventions from around the world that illustrate what can be done.

From single to comprehensive packages of ECD services

The implementation of programmes and services that seek to improve the development of young children can follow a number of models. Some are directed to single issues, such as early literacy (Box 5.2), while others deal with ECD more comprehensively (see Boxes 5.3 and 5.4).

Interventions that integrate the different dimensions of child development, among others by incorporating stimulation (interaction between caregivers and children, which is related to brain development) and nutrition, are particularly successful (Engle et al., 2007). They tend to result in sustained improvements in physical, social/emotional, and language/cognitive development, while simultaneously reducing the immediate and future burden of disease, especially for those who are most vulnerable and disadvantaged (ECDKN, 2007a). This is illustrated in Fig. 5.1, which shows that the mental development of stunted children who were given both food supplementation and psychosocial stimulation was about as good as that of non-stunted children (Fig. 5.1).

BOX 5.2: STIMULATING READING OUT LOUD – UNITED STATES

Reach Out and Read is a United States national non-profit organization that promotes early literacy by giving books to children and advice to parents attending paediatric examinations about the importance of reading aloud for child development and school readiness. At every check-up, doctors and nurses encourage parents to read aloud to their young children, and offer age-appropriate tips and encouragement. Parents who may have difficulty reading are encouraged to invent their own stories to go with picture books and spend time naming objects with their children. Also, providers give every child between the ages of 6 months and 5 years developmentally appropriate children's books to keep. In literacy-rich waiting-room environments, often with volunteer readers, parents and children learn about the pleasures and techniques of looking at books together. Parents who have received the intervention were significantly more likely to read to their children and have more children's books at home. Most importantly, children who received the interventions showed significant improvements in preschool language scores – a good predictor of later literacy success.

Source: ECDKN, 2007a

Even more integrated packages of services can be provided, including stimulation, nutrition, parental education, and various forms of family support (Box 5.3).

Starting early in life, using a lifecourse approach

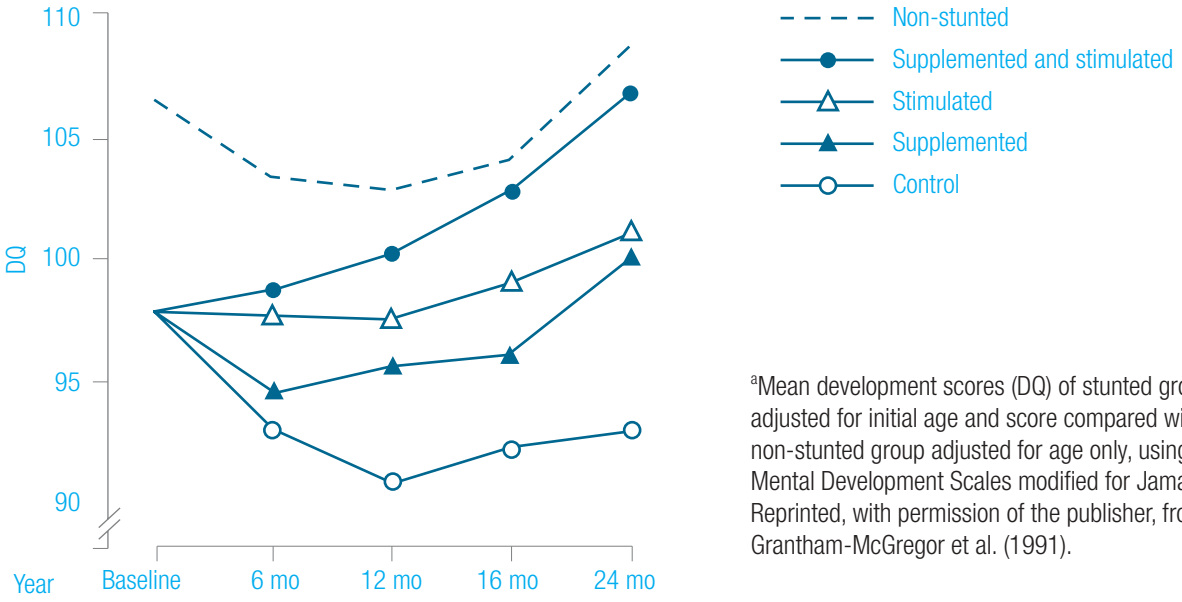
Younger children tend to benefit more from ECD interventions than older children, emphasizing the importance of providing programmes and services as early in life as possible (Engle et al., 2007). Some factors need to be addressed before birth – even before conception. Box 5.4 illustrates how child development and nutrition problems can be addressed through a lifecourse perspective, including not just children, but also pregnant and lactating mothers and adolescent girls.

Prioritizing the provision of interventions to the socially most disadvantaged

Within a framework of universal access, special attention to the socially disadvantaged and children who are lagging behind in their development will help considerably to reduce inequities in ECD. An important reason is that ECD interventions tend to show the largest effect in these disadvantaged groups (Scott-McDonald, 2002; Young, 2002; Engle et al., 2007).

Unfortunately, children in the poorest households and communities are usually least likely to have access to ECD programmes and services (UNESCO, 2006b). When new interventions are introduced, the better off tend to benefit

Figure 5.1: Effects of combined nutritional supplementation and psychosocial stimulation on stunted children in a 2-year intervention study in Jamaica.[a]



[a]Mean development scores (DQ) of stunted groups adjusted for initial age and score compared with a non-stunted group adjusted for age only, using Griffiths Mental Development Scales modified for Jamaica. Reprinted, with permission of the publisher, from Grantham-McGregor et al. (1991).

BOX 5.3: A COMPREHENSIVE APPROACH TO ADDRESSING EARLY CHILD DEVELOPMENT CHALLENGES IN JAMAICA

Young children in poor Jamaican communities face overwhelming disadvantages, among others of poverty. The Malnourished Children's Programme addresses the nutritional and psychosocial needs of children admitted to the hospital for malnutrition. Hospital personnel observed that, before initiation of their outreach programme, many children who recovered and were sent home from the hospital had to be readmitted for the same condition shortly after. To address this, follow-up home visits were set up to monitor children discharged from hospital. During home visits, staff focus on stimulation, environmental factors potentially detrimental to the child's health, the child's nutritional status, and the possible need for food supplementation. Parents participate in an ongoing weekly parenting education and social welfare programme. They are helped to develop income-generating skills, begin self-help projects, and find jobs or shelter. Unemployed parents are also provided with food packages, bedding, and clothing. In addition, there is an outreach programme in poor communities, including regular psychosocial stimulation of children aged 3 and under, supported by a mobile toy-lending library.

Adapted, with permission of the publisher, from Scott-McDonald (2002).

first (Victora et al., 2000; Houweling, 2007). This seems to be the case for the Integrated Management of Childhood Illness programme which, when implemented under routine conditions, does not preferentially reach the poor (PPHCKN, 2007a). On the other hand, examples from, among others, the Philippines illustrate that reaching disadvantaged children is feasible (Box 5.5). In countries where resources are limited, priorities must be set such that the most vulnerable children are reached first, while universal coverage should remain the longer-term goal (ECDKN, 2007a).

Reaching all children

A core objective should be universal coverage for quality ECD interventions (Box 5.6), with special attention to the most deprived. Universal access must include equal access for girls and boys as a matter of course. Low-income countries should strive to progressive realization of universal coverage, starting with the most vulnerable. Governments need to develop strategies for scaling up effective programmes from the local to the national level, without sacrificing the characteristics of the programme that made it effective. It is important that implementation integrity and accountability at the local level are sustained, even when programmes are scaled up to the national level (ECDKN, 2007a).

BOX 5.4: STARTING INTERVENTIONS BEFORE CONCEPTION – THE INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS), INDIA

The ICDS is one of the largest child development and child nutrition programmes in the world, currently serving more than 30 million children. The services include support for pregnant and lactating mothers and adolescent girls, among others through improving their access to food. They also include childcare centres, preschool education, growth monitoring for children aged 0-5 years, supplementary feeding for malnourished children, assistance for child immunization, and some emergency health care (Engle et al., 2007). The results of the programme appear to be mixed, with positive results on malnutrition and child motor and mental development in some states (Engle et al., 2007; Lokshin et al., 2005). Within states, poorer villages were more likely to be served. However, states with high levels of child malnutrition have lowest programme coverage and lowest budgetary allocations from the central government (Das Gupta et al., 2005). An evaluation by the World Bank found "only modest positive effects, probably because of low funding, work overload of community workers, and insufficient training"

(Engle et al., 2007).

BOX 5.5: REACHING MARGINALIZED COMMUNITIES IN THE PHILIPPINES

"A programme in the Philippines provides health, nutrition and early education services to young children in marginalized communities. Involving various ministries at the national level, and extension agents and Child Development Officers at the community level, the programme helps track every child's growth; monitors access to iodized salt, micronutrients, clean water and a toilet; and counsels parents on nutrition and child development."

Reprinted, with permission of the author, from UNICEF (2001).

BOX 5.6: UNIVERSAL CHILD DEVELOPMENT SERVICES IN CUBA

Cuba's Educa a Tu Hijo (Growing-up with your child) programme is generally thought to be an important factor in Cuba's educational achievements at the primary school level (UNICEF, 2001). The programme, introduced in 1985, is a non-formal, non-institutional, community-based, family-centred ECD service under the responsibility of the Ministry of Education (Preschool Education). The programme operates with the participation of the Ministries of Public Health, Culture, and Sports, the Federation of Cuban Women, the National Association of Small Farmers, the National Committee for the Defence of the Revolution, and student associations. This extended network includes 52 000 Promotres (teachers, pedagogues, physicians, and other trained professionals), 116 000 Executors (teachers, physicians, nurses, retired professionals, students, and volunteers), and more than 800 000 families. During the 1990s the programme was extended, reaching 99.8% of children aged 0-5 years in 2000 – probably the highest enrolment rate in the world.

Source: CS, 2007

Building onto established child survival and health programmes to make early child development interventions readily accessible

Health-care systems are in a unique position to contribute to ECD (see Chapter 9: *Universal Health Care*). Given the overlap in underlying determinants of survival/physical development and social/emotional and language/cognitive development, the health-care system can be an effective site for promoting development in all domains. The health-care system is a primary contact for many child-bearing mothers and, in many instances, health-care providers are the only professionals with whom families come into contact in the early years of the child's life (ECDKN, 2007a). Health-care systems can serve as a platform for information and support to parents around ECD, and they can link children and families to existing community-based ECD services. When ECD programmes and services become integral components of established health-care services, such as the IMCI (Box 5.7), they can become a highly effective way of promoting ECD (ECDKN, 2007a).

Acting on gender inequities

An important aspect of the quality of ECD programmes and services is the promotion of gender equity. Early gender socialization, the learning of cultural roles according to one's sex and norms that define 'masculine' and 'feminine', can have large ramifications across the lifecourse. Girls, for example, may be required to care for their younger siblings, which can prevent them from attending school. Preschool programmes that take care of the younger siblings can contribute to solving this problem.

An important strategy in promoting positive gender socialization for young boys and girls is through developmentally appropriate, gender-sensitive, and culturally relevant parenting programmes (Koçak, 2004; UNICEF, 1997; Landers, 2003). These seek to raise awareness among parents and caregivers of their role in helping their children to develop self-esteem and confidence as a boy or girl from the beginning of their lives. Gender-biased expectations of boys and girls can be brought up during group discussions with fathers and mothers as well as other caregivers and preschool teachers.

Involving fathers in child-rearing from their children's birth is another important strategy for improving child health and developmental outcomes, while promoting gender equity. Fathers can enjoy their fatherhood roles while establishing a positive and fulfilling relationship with their children and can be a positive role model for both their daughters and sons. Parenting programmes in, for example, Bangladesh, Brazil, Jamaica, Jordan, South Africa, Turkey, and Viet Nam include specific activities to engage fathers more actively in the upbringing of their children (Koçak, 2004; UNICEF, 1997; Landers, 2003).

Involving communities

The involvement of communities, including mothers, grandmothers, and other caregivers, is key to the sustainability of action on ECD. This includes involvement in the development, implementation, monitoring, and reviewing of ECD policies, programmes, and services (ECDKN, 2007a). It can build a common purpose and consensus regarding outcomes related to the needs of the community, foster partnership among the community, providers, parents, and caregivers, and enhance community capacity through active involvement of families and other stakeholders (ECDKN, 2007a). Box 5.8 shows how an ECD project in the Lao People's Democratic Republic was community driven, at all stages, from identification of need to implementation. Community participation and community-based interventions do not absolve governments from their responsibilities. However, they can ensure stronger relationships between government, providers, the community, and caretakers (ECDKN, 2007a) (see Chapter 14: *Political Empowerment – Inclusion and Voice*).

The scope of education

While the Commission has not investigated education through a dedicated Knowledge Network, broad areas for attention have emerged from the Commission's work. The Commission recognizes the critical importance of education for health equity. Education, formal and informal, is understood as a lifelong process starting at birth. The focus in this section is on education from pre-primary to the end of secondary school, with an emphasis on extending the comprehensive approach to education that incorporates attention to children's physical, social/emotional, and language/cognitive development.

BOX 5.7: BUILDING EARLY CHILD DEVELOPMENT ONTO EXISTING HEALTH PROGRAMMES AND SERVICES

In partnership with UNICEF, WHO has developed a special early childhood development component, called Care for Development, intended to be incorporated into existing IMCI programmes. Care for Development aims to enhance awareness among parents and caregivers of the importance of play and communication with children by providing them with information and instruction during children's clinical visits. Evidence has shown that Care for Development is an effective method of supporting parents' and caregivers' efforts to provide a stimulating environment for their children by building on their existing skills. Health-care professionals are encouraged to view children's visits for acute minor illnesses as opportunities to spread the messages of Care for Development, such as the importance of active and responsive feeding to improve children's nutrition and growth, and the importance of play and communication activities to help children move to the next stages in their development.

Sources: ECDKN, 2007a; WHO, nd,d

The Commission recommends that:

5.3. Governments provide quality education that pays attention to children's physical, social/emotional, and language/cognitive development, starting in pre-primary school.

In every country children, particularly those from the poorest communities, would benefit immensely from early education programmes. Expanding and improving early childcare and education is part of the UNESCO Education for All strategy (UNESCO, 2006b; UNESCO, 2007a). The Commission supports the UNESCO Education for All goals (summarized in Box 5.9).

Providing quality pre-primary education

Extending the availability of quality pre-primary school, which adopts the principles of ECD, to all children and making special efforts to include those from socially disadvantaged backgrounds requires a commitment from the highest level of government and from ministries responsible for care and education of young children. It requires joint working across health and education sectors, and review of existing pre-primary provision involving broad consultation with families, communities, nongovernmental and civil society organizations, and preschool providers to identify needs and develop a comprehensive strategy. Areas to be addressed in strategy development include: levels of funding, infrastructure (including buildings and facilities), support for children with special educational needs, ratio of staff to children, recruitment, support and training of preschool staff, and the nature of the preschool programme.

BOX 5.8: VILLAGE-BASED EARLY CHILD DEVELOPMENT CURRICULUM DEVELOPMENT IN THE LAO PEOPLE'S DEMOCRATIC REPUBLIC

The Women's Development Project worked to promote various development initiatives for women in five Lao provinces. After 5 years, interest developed and a need was identified to address child development issues more directly. The Early Childhood and Family Development Project grew out of this. Project-planning workshops were organized in villages in the initial steps of development and implementation. Village-level planning resulted in agreement on needs and objectives, an understanding of overall design, assessments of resources and constraints, activity planning, setting up the project committee, and criteria for selecting village volunteers. The community-based curriculum-development process focused on participatory input at the local level to create a curriculum that could be adapted to the particular needs of different ethnic groups. The process focused on village data collection and needs assessment. Analysis of existing traditional knowledge was used as a basis for curriculum development. One of the notable activities was a village engagement agreement signed by village members and the village development committee. It was based on a child rights framework and included actions that could be taken immediately while waiting for needed external assistance.

Source: ECDKN, 2007a

PROVISION AND SCOPE OF EDUCATION : ACTION AREA 5.2

Expand the provision and scope of education to include the principles of early child development (physical, social/emotional, and language/cognitive development).

BOX 5.9: UNESCO EDUCATION FOR ALL GOALS

- Expand and improve early childcare and education.
- Provide free and compulsory universal primary education by 2015.
- Ensure equitable access to learning and life-skills programmes.
- Achieve a 50% improvement in adult literacy rates.
- Eliminate gender disparities in primary and secondary education by 2005 and at all levels by 2015.
- Improve all aspects of the quality of education.

Source: UNESCO, 2007a

Quality primary and secondary education

There is emerging evidence that integrating social and emotional learning in curricula in primary and secondary schools as well as attention to the children's physical and cognitive/language development improves school attendance and educational attainment (CASEL, nd), and potentially would have consequent long-term gains for health. Social and emotional learning comes under the broad umbrella of life-skills education, which is incorporated into UNICEF's definition of quality education (UNICEF, nd,b). The Education for All goals include equitable access to 'life skills' as a basic learning need for young people, to be addressed either through formal education or non-formal settings (UNESCO, 2007a). The Commission endorses increased attention to life skills-based education in all countries as a way of supporting healthy behaviours and empowering young people to take control of their lives. UNICEF has highlighted the importance of life-skills education for HIV/AIDS prevention and a comprehensive approach to quality education that responds to learners' needs and is committed to gender equity (UNICEF, nd,c).

Making schools healthy for children is the basis for the FRESH (Focusing Resources on Effective School Health) Start approach (Partnership for Child Development, nd), a joint initiative by WHO, UNICEF, UNESCO, the World Bank, and other partners to coordinate action to make schools healthy for children and improve quality and equity in education, contributing to the development of child friendly schools (Box 5.11).

Innovative, context-specific, school-based interventions can be developed to tackle health challenges faced by young people. For example, in Australia the MindMatters programme (Curriculum Corporation, nd) has been developed to promote mental health in schools, and in the United States the Action for Healthy Kids programme addresses the growing obesity epidemic (Action for Healthy Kids, 2007). These programmes demonstrate how working across sectors and involving a range of both governmental and NGOs can address health challenges in the school setting. Out-of-school programmes in non-formal settings can also be developed to achieve similar objectives using the same approach.

Barriers to education

The Commission recommends that:

5.4 Governments provide quality compulsory primary and secondary education for all boys and girls, regardless of ability to pay, identify and address the barriers to girls and boys enrolling and staying in school, and abolish user fees for primary school (see Rec 6.4; 13.4).

Barriers to education include issues of access to education and quality and acceptability of education. In many countries, but particularly low-income countries, it is children from families on low incomes and with parents with little education who are less likely to attend school and more likely to drop out of school. Poverty relief and income-generating activities (discussed in Chapters 7 and 8: *Fair Employment and Decent Work; Social Protection across the Lifecourse*) together with measures to reduce family out-of-pocket expenditure on school attendance, school books, uniforms, and other expenses are critical elements of a comprehensive strategy to make access to quality education a reality for millions of children.

Other policies aimed at encouraging parents to send their children to school vary by country but include provision of free or subsidized school meals (Bajpai et al., 2005) and providing cash incentives conditional on school attendance, removal of school fees (Glewwe, Zhao & Binder, 2006), and provision of free deworming tablets or other health interventions, for example, the Malawi School Health Initiative (Pasha et al., 2003). Context-specific analyses are needed to identify barriers to education and to develop and evaluate policies that encourage parents to enrol and keep children in school.

BOX 5.10: COUNTRY APPROACHES TO PRE-PRIMARY EDUCATION

In Chile, the expansion of pre-primary education for socially disadvantaged children began by extending provision first for ages 5-6, then ages 4-5, then ages 3-4. The programme focuses on integrating quality education, care, nutrition, and social attention for the child and his or her family care (JUNJI, nd).

Expansion of preschool education in Sweden was achieved with a government commitment that preschool education should have an emphasis on play, children's natural learning strategies, and their comprehensive development. It was a policy goal to integrate this comprehensive approach to education into the entire education system (Choi, 2002).

BOX 5.11:CHILD FRIENDLY SCHOOLS

UNICEF has developed a framework for child friendly schools that takes a rights-based approach to education. Child friendly schools create a safe, healthy, gender-sensitive learning environment, with parent and community involvement, and provide quality education and life skills. This model or similar models are now developed or being developed in more than 90 countries, and adapted as national quality standard in 54 countries.

Source: UNICEF, nd,d

Of note, there has been rapid expansion of primary education in low-income countries over recent years, a trend attributed, in part, to the abolition of school fees in a number of countries. As the Kenyan experience highlights (Box 5.12), abolishing primary school fees needs to be complemented by hiring and training teachers, building more schools and classrooms, and providing educational materials. Increased access to primary school needs to be accompanied by attention to quality of education. In addition, expansion of primary education will require investments in secondary education to increase capacity for the new entrants, assuming they reach secondary level. The transition from primary to secondary school is a critical point for girls and for gender equity (Grown, Gupta & Pande, 2005).

A major investment is required by national governments – allocating sufficient funds to school infrastructure development, the recruitment, training, and remuneration of staff, and the provision of educational materials. Supporting low- and middle-income countries to do this requires donor countries to fulfil their aid commitments (see Chapter 11: *Fair Financing*). The annual external financing requirement to meet the 'Education for All' goals is estimated to be about US$ 11 billion per annum (UNESCO, 2007a).

Educating girls

There needs to be a particular effort in securing primary and secondary education for girls, especially in low-income countries (UNESCO, 2007a, Levine et al., 2008). Abolishing user fees for primary education is a critical step. In response to continued challenges to gender equity in education, Task Force 3 on Education and Gender Equality of the UN Millennium Project identified the need to strengthen opportunities for secondary education for girls while simultaneously meeting commitments to universal primary education as key to achieving MDG 3 – promote gender equality and empower women (Grown, Gupta & Pande, 2005).

Strategies for promoting secondary education for girls include increasing access and retention. Interventions to improve both the physical and social environment (Rihani, 2006) include building functional toilets/latrines for girls and female teachers and creating a safe environment for girls (WHO, 2005a) by introducing and enforcing codes of conduct. Measures to improve the relevance and quality of schooling (Rihani, 2006) include teacher training and curriculum reform to reduce gender biases and introducing frameworks for participation of girls in decisions about their schooling. Other interventions include targeted scholarships for girls, such as the Bangladesh's Female Secondary School Assistance Programme (WGEKN, 2007; SEKN, 2007), and programmes that address the needs of pregnant schoolgirls, such as the Botswana Diphalana Initiative (WGEKN, 2007).

Early childhood offers huge opportunities to reduce health inequities within a generation. The importance of early child development and education for health across the lifecourse provides a strong imperative to start acting now. Inaction will have detrimental effects that can last more than a lifetime. A new approach is needed that embraces a more comprehensive understanding of early child development and includes not just physical survival but also social/emotional and language/cognitive development. This approach should be integrated into lifelong learning.

BOX 5.12: KENYA – ABOLITION OF SCHOOL FEES

When Kenya abolished school fees in 2003, there was an immediate influx of 1.3 million children into the school system, overwhelming school infrastructure and teachers. School enrolments since 2002 increased by 28% while the total number of teachers increased by only 2.6% between 2002 and 2004; in some areas the ratio rose to one teacher for 100 pupils.

Source: Chinyama,2006

BOX 5.13: DEMAND FOR QUALITY EDUCATION, SUB-SAHARAN AFRICA

The total fertility rate in sub-Saharan Africa is 5.5 (UNDP, 2007); Niger and Uganda have particularly high fertility rates (Niger 7.4, Uganda 6.7). Nearly 44% of the total population of sub-Saharan Africa is under 15 years old, compared with approximately 18% in high-income OECD countries. With so many children of school age, some countries in sub-Saharan Africa face particular challenges in ensuring high-quality education for all.