Ministry of Health, Welfare and Sport

Solid Start

The Action Programme

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Introduction:

Why ***Solid Start*** action programme?

Every child deserves the best possible start to their life and the best opportunity of having a good future. A child's first 1,000 days are crucial to getting off to a good start[1]. A child's health ***before***, ***during*** and ***after*** birth appears to be an important predictor of problems - both physical and mental - in later life.

Much has already been invested in order to reduce infant mortality in the Netherlands. Fortunately, most babies therefore do well at birth. But some get off to a poor start, because they are born too early, weigh too little at birth, or both. A baby who is exposed to stress, second-hand smoke, poor nutrition, abuse or other risk factors during the first 1,000 days starts its life off at a disadvantage. These factors reduce children's ability to develop physically, mentally and socially. Those first 1,000 days start in the womb. For the health and development of a child, it should not matter where he or she is born. The health of babies around the time of their birth therefore entails important tasks for all of us: parents, society, professionals and the government. With this action programme, we will therefore be investing in a solid start for as many children as possible.

A good start begins already before birth - even before conception and pregnancy. The state, municipalities, obstetric care and youth healthcare, adult mental-health care, welfare work teams and district teams can make all the difference here. It is they who are best placed to promote, and work actively to enhance, the value of the first 1,000 days. We call on municipalities and all professionals in the social and medical fields to contribute to this effort. In this action programme, we explain *why* a solid start is so important, *what steps* we will be taking to give more children a solid start, and *how* we will be measuring the progress they make.

Here are a few figures about babies in the Netherlands:

- 167,595 children were born in 2017.[2]
- Somewhere between 0.5% and 1% of children (between 800 and 1,700 per year) are born into vulnerable or very vulnerable families.[3] They run the risk of being put into care.
- About 16.5%[4] of children (almost 28,000 each year) do not get off to a good start at birth because they are born prematurely, are underweight, or both.[5]
- Children who get off to a poor start at birth will later experience more growth and development problems, including as regards their psychological development, as well as diabetes, cardiovascular disease and obesity.[6]

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1 Dutch Youth Health Centre. (2017). *Gezonde, kansrijke en veilige generatie [A Safe, Healthy and Promising Generation]* (position paper).

2 De Staat van Volksgezondheid en Zorg, *Kerncijfer geboorten 2017* [The State of Public Health and Care, *Key Figures for Births 2017*], https://www.staatvenz.nl/kerncijfers/geboorten.

3 Mejdoubi J., Heijkant S. van den, Struijf E., Leerdam F. van, Hira Sing R. A., and Crijnen A. (2013). Risicofactoren voor kindermishandeling bij jonge hoogrisicozwangeren: design van het VoorZorgonderzoek, [Risk factors for Child Abuse in Cases of High-Risk Pregnancy in Young Mothers: Design of the Preventive-Care Study], *Tijdschrift voor Jeugdgezondheidszorg*, 2, 26-31.

4 The Dutch version of this programme mentions 14%. In the translation, this percentage was changed to 16.5%, due to the international use of new growth curves.

5 Waelput, A. J. M., et al. (2017). Geographical Differences in Perinatal Health and Child Welfare in the Netherlands: Rationale for the Healthy Pregnancy 4 All-2 Program. *BMC, Pregnancy and Childbirth.*

6 Potijk, M. R., Winter, A. F. de, Bos, A. F., Kerstjens, J. M., & Reijneveld, S. A. (2012). Higher Rates of Behavioural and Emotional Problems at Preschool Age in Children Born Moderately Preterm. *Archives of Disease in Childhood, 97*, 112-117. Grantham-McGregor, S. & Ani, C. (2001). A Review of Studies on the Effect of Iron Deficiency on Cognitive Development in Children. The Journal of Nutrition. 131 (2S-2), 649S-666S; discussion 666S-668S. Uijterschout, L., Vloemans, J. & Vos R., et al. (2014). Prevalence and Risk Factors of Iron Deficiency in Healthy Young Children in the Southwestern Netherlands. Journal of Pediatric Gastroenterology and Nutrition, 58, 193-198.

1. The problem: too many children do not get off to a good start

In the Netherlands, most children get off to a healthy start at birth and grow up healthy and safe. Infant mortality was higher than in other European countries. On the basis of the advice in *A Good Start*,[7] obstetric caregivers have worked hard to reduce infant mortality. The most recent figures show that considerable gains have been made here.[8] Infant mortality in the Netherlands (from 22 weeks into pregnancy up to 28 days after birth) fell by almost 20% between 2010 and 2016, from 9.0 out of 1,000 babies in 2010 to 7.3 out of 1,000 in 2016.[9] Indeed, compared to 2000, the decrease is 39%, from 11.9 out of 1,000 babies in 2000 down to 7.3 out of 1,000 in 2016. That being said, about 16.5%[10] of children do not get off to a good start at birth because they are born prematurely, are underweight, or both.[11] This is mainly because of social risk factors and the lack of protection factors.

Tessa Roseboom, professor of Early Development and Health in the Faculty of Medicine at the University of Amsterdam does research on children's development in the first 1,000 days of life </1473> and how that affects their health at a later stage. "The development we go through from being just a fertilised egg to being a 2-year-old toddler is phenomenal and makes us, in large part, who we are." During no other period in life, so many biological milestones are reached. All our organs are formed, our immune system develops, we bond with others, we learn to crawl, stand and walk, we learn to eat and drink, we learn to communicate, we say our first words, and we learn essential life lessons about cause and effect. It is on this foundation that we build the rest of our lives. This period is therefore crucial to the proper development of young children, their health as adults, and the health of future generations. If you do not go through this period properly, you are getting off to a poor start.

7 Stuurgroep Zwangerschap en Geboorte [Pregnancy and Birth Steering Group] (2009). *A Good Start*.

8 Letter from the Minister for Medical Care, dated 13 March 2018, 29214-76.

9 Perined. (2016). Factsheet Zwangerschap en Geboorte [Fact Sheet on Pregnancy and Birth].

10 The Dutch version of this programme mentions 14%. In the translation, this percentage was changed to 16.5%, due to the international use of new growth curves.

11 Waelput, A. J. M. et al. (2017). Geographical differences in Perinatal Health and Child Welfare in the Netherlands: Rationale for the Healthy Pregnancy 4 All-2 Programme. *BMC, Pregnancy and Childbirth.*

If a child in this formative phase is exposed to stress, second-hand smoke, poor nutrition, abuse or other risk factors, that is the root cause of differential health outcomes. These large differences in the prospects of a long and healthy life have little to do with hereditary factors, and everything to do with the circumstances in which children develop and grow up.[12]

The first 1,000 days are therefore decisive, not only for healthy growth and development in the womb,[13] but also for the prospects of optimal development in later life.[14] It is precisely because the development of a child in this period goes really fast that it is of fundamental importance that it also goes well: there is only one chance at a good start. The heart cannot be rebuilt, and neither can the brain. If its development does not go well, a child will be affected for life. It will to fight the rest of its life to deal with that disadvantage. The Health Council of the Netherlands also points out, in its advice, the importance of a good start in the first 1,000 days.[15] Fortunately, most children grow up healthy.

But the differences among municipalities and even among neighbourhoods are sometimes significant when it comes to the health of babies. Babies born in deprived areas are at greater risk of getting off to a poor start.[16] In some areas of cities such as Rotterdam and Amsterdam, the risk of death and birth-related illnesses is two to three times higher than the national average. For example, there is a 20%-higher chance of infant mortality, a 16%-higher chance of premature birth, and an 11%-higher chance that the growth of the baby in the womb will be weaker. Approximately 85% of perinatal mortality is associated with the four major perinatal conditions, known as the Big 4: congenital abnormalities, premature birth, low birth weight and low Apgar score.[17] Stress in parents - for example as a result of domestic violence, relationship problems, psychosocial problems, addiction, mild intellectual disabilities, lifestyle, criminality, noise pollution, housing problems, debts or unemployment - is an important risk factor. Sometimes this social risk even outweighs the medical and obstetric risks. Of course, there are also vulnerable families where, despite the problems they have, the children grow up healthy and safe into independent adults. However, these children are more likely to be at a disadvantage. Problems during their first 1,000 days have direct consequences for their health and development. This not only is the case with younger children, but also affects children at a later age, and even has an impact on future generations.

On 22 May 2018, the Health Council of the Netherlands issued its advice *De ouder-kindrelatie en jeugdtrauma's [The Parent-Child Relationship and Youth Traumas]*.[18] According to the Health Council of the Netherlands, for the development of a child to be healthy, it is crucial that it get off to a good start in the first 1,000 days. This start consists of a healthy pregnancy, as few negative childhood experiences as possible, and the ability of parents to respond sensitively to the child. Therefore, vulnerable parents in particular should receive appropriate support aimed at alleviating stress and promoting sensitive parenting. It is also important to support children of vulnerable parents as much as possible.

A child who is not in good health and who does not have a stimulating environment during the birth and in its first years of life, runs a greater risk later on of physical and mental problems, diabetes, cardiovascular disease and obesity.[19] Stress in parents is also an important risk factor. Sometimes this social risk even outweighs the medical and obstetric risks.

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12 Roseboom, T. (2018). *De eerste 1000 dagen: Het fundamentele belang van een goed begin vanuit biologisch, medisch en maatschappelijk perspectief [The First 1,000 Days: the Fundamental Importance of a Good Start from a Biological, Medical and Social Perspective]*. Utrecht: Uitgeverij de Tijdstroom.

13 Dutch Youth Health Centre. (2017). *Gezonde, kansrijke en veilige generatie [A Safe, Healthy and Promising Generation]* (position paper).

14 Barker, J. (2007). The Origins of the Developmental Origins Theory. *Journal of Internal Medicine*. Steegers, E. A. P. (2014). Embryonale gezondheid en preconceptiezorg [Embryonic health and preconception care]. Nederlands Tijdschrift Geneeskunde.

15 Gezondheidsraad. (2018). *De ouder-kindrelatie en jeugdtrauma's [The Parent-Child Relationship and Youth Traumas]*.

16 Bonsel, G. J., et al. (2010). *Lijnen in de Perinatale Sterfte, Signalementstudie Zwangerschap en Geboorte [Approach to perinatal mortality in the Netherlands: outcomes of a systematic expert study]*. Rotterdam: Erasmus MC. Poeran, J., et al. (2012). De aanpak van perinatale sterfte in Nederland [Tackling Perinatal Mortality in the Netherlands]. *Nederlands Tijdschrift Geneeskunde*.

17 Steegers, E. A. P. (2017). Sociale verloskunde in Nederland [Social Midwifery in the Netherlands]. *Nederlands Tijdschrift Geneeskunde*.

18 Gezondheidsraad. (2018). *De ouder-kindrelatie en jeugdtrauma's [The Parent-Child Relationship and Youth Traumas]*.

19 Roseboom, T.J. et al. (2018). *De eerste 1000 dagen [The First 1,000 Days:]*.

For example, stress during pregnancy can negatively influence the cerebral development of the child.[20] As a result of stress, parents can show less warmth and affection to their child or respond less adequately to its needs (sensitive parenting).[21] Parents who abuse or neglect their child are quite often mentally or psychiatrically ill. There is a greater risk that parents who were themselves abused as children, or who have experienced other negative experiences in the family in their childhood, will abuse their own child. Inadequate parenting skills and stress in parenting are major risk factors for child abuse. Sometimes parents have expectations of their child that are too high, while others have no expectations at all. Yet others regard their child negatively or fail to respond sympathetically to them. They often want to do things differently but do not know how, and for a variety of reasons they cannot change the situation.[22]

Children from vulnerable families usually grow up without problems, but more often than not are in an environment where they cannot develop to their full potential. These families have to deal with risk factors such as low socio-economic status (a low level of education, poverty, unemployment, crime, a deprived neighbourhood), family make-up and level of education (single parenthood, teenage motherhood, inappropriate parenting, domestic violence, relationship problems), poor health and addiction of parents (long-term disorder or disability, emotional or psychosocial problems, addiction problems), and poor health and temperament of the children themselves (long-term disorder or disability, intellectual disability, low birth weight, difficult temperament).[23] Of course, there are also children who grow up healthy despite these risk factors, and good information, support and guidance can have a positive effect on these risk factors. This applies to both social conditions and mental and physical health. In addition, protective factors can also be influenced in the case of the guardian, a child or their environment, and this reduces the negative influence that risky situations have.[24] Protective factors include warmth and affection on the part of the parent towards the child, practical and emotional support from the social network, parents' willingness to accept help, and their self-esteem, self-confidence and social competence. In its policy letter dated 27 August 2018,[25] the Scientific Council for Government Policy also points out the importance of policy aimed at parents and parents-to-be by, for example, linking the medical and social domains, in the preconception phase and during pregnancy, to the effects of poverty and deprivation on perinatal health.

In Rotterdam, professionals and municipalities in various deprived neighbourhoods and districts registered more premature births, more babies who are born underweight, and an infant-mortality rate that is considerably higher than that in other districts of the city and also higher compared to the national average. Midwives noticed that more expectant mothers needed social support. At the same time, they saw an insufficient link between the medical and the social domains, and a lack of clear healthcare pathways.

[20] Franklin, T. B., et al. (2010). Epigenetic Transmission of the Impact of Early Stress across Generations. *Biological Psychiatry*.

[21] Gezondheidsraad. (2018). *De ouder-kindrelatie en jeugdtrauma's [The Parent-Child Relationship and Youth Traumas]*.

[22] Netherlands Youth Institute, *Risicofactoren en beschermende factoren [Risk Factors and Protective Factors]*, https://www.nji.nl/kindermishandeling-probleemschets-risicofactoren.

[23] Broek, A. van den, Kleijnen, E., & Bot, S. (2012). Kwetsbare gezinnen in Nederland [Vulnerable Families in the Netherlands]. In Council for Social Development, *Ontzorgen en normaliseren: Naar een sterke eerstelijns jeugd- en gezinszorg [Relief and Normalisation: Towards Strong Primary Care for Youth and Families]*. The Hague: Council for Social Development.

[24] Netherlands Youth Institute, *Risicofactoren en beschermende factoren [Risk Factors and Protective Factors]*, https://www.nji.nl/kindermishandeling-probleemschets-risicofactoren.

[25] Scientific Council for Government Policy (2018), *Van verschil naar potentieel [From Divergence to Potential]*.

There was an increase in domestic violence and an increase in the number of evictions. That is why, in 2016, Rotterdam designed Soli*d Start* programme together with professionals in the city, with the goal of ensuring that more children in Rotterdam are born healthy and offer the best opportunities for development. Soli*d Start* programme gives concrete shape to the municipal policy on pregnancy, birth and the raising of the youngest children. The programme focuses on parents and parents-to-be, from before pregnancy up until a child goes to school. The programme also helps professionals to identify risks with a view to prevention. Finally, the programme tackles, through targeted interventions at an early stage, the risks that parents and children can run. Soli*d Start* programme has put perinatal care and the link between the medical and social domains high up on municipalities' agendas.

By no means all vulnerable pregnant women and young children at risk are currently being reported by professionals, with the result that they miss out on the right support or help. Even if these parents and children are identified, professionals sometimes lack clarity about whom to make referrals to, or are not entirely sure about what their cases involve. In addition, it can happen that vulnerable pregnant women and young parents do not ask for help in time, or do not know where to turn for help with their questions. If it is possible to identify risks that are experienced during pregnancy and by young parents, and then offer the right support or help, many problems the child might otherwise go through can be prevented. Problem cases can be identified, and good referrals can be made in any of the places these parents and parents-to-be go to: the practices of midwives, gynaecologists and maternity care organisations, at facilities for people with a minor mental disability or who are getting mental healthcare, at youth healthcare facilities, neighbourhood-team locations, or youth centres. Depending on the request for help, the social neighbourhood team, the social-welfare team, the debt-assistance service, youth healthcare services or other institutions can offer help. Municipalities play an essential role in this process. If we can get help to the family in question sooner, we can overcome problems in their development, or at least deal with them earlier and more effectively. This may prevent children from having to be put into care or from ending up in a home for youth at a later age.

Summary

In order to offer every child a healthy, safe and solid start, more national and local attention needs to be paid to the first 1,000 days. There are many opportunities for municipalities here: after all, every baby is a future resident of a municipality and therefore worth investing in. More, and higher-quality, attention to the social, mental and physical conditions of vulnerable families (or families in the making) can improve the prospects for babies and toddlers, and prevent problems.

That is why this action programme aims to provide vulnerable families - including families where there is a precarious situation when it comes to child-rearing, whether temporary or otherwise - with additional support regarding pregnancy as an active choice, healthy pregnancy and parenting safely. A good link between the medical and the social domains, including public health, is essential to ensuring that more children get a solid start. Municipalities have an important role to play in this.

[26] Ministry of Health, Welfare and Sport, Ministry of Justice and Security. (2018). *Action Programme for Youth Care*.

2. The goal: to get more children off to a solid start

The aim of this action programme is to get more children off to a solid start. In the Netherlands, 16.5%[27] of children get off to a poor start at birth. Children who get off to a poor start at birth[28] will later experience growth and development problems more often, including as regards their psychological development, as well as diabetes, cardiovascular disease and obesity. They will also come into contact far more often with youth aid.

To ensure that more children get off to a solid start, we want:
1. more vulnerable parents to be well prepared when they start their pregnancy;
2. there to be fewer unplanned and unintended pregnancies in vulnerable families;
3. problems (including non-medical ones) to be identified in families that are vulnerable or that could be in the future;
4. more vulnerable prospective parents to get the help they need sooner;
5. more vulnerable parents to be equipped for parenthood and raising children; and
6. fewer babies and young children to be placed out of home or under supervision.

Solid *Start* action programme focuses on children in the first 1,000 days of their lives, especially those born into vulnerable situations. Other action programmes focus on other stages of children's lives. *Care for Youth*, for example, is about improving youth aid, youth protection and youth rehabilitation, so that children, youth and parents receive the help they need in good time. The *No Place at All for Domestic Violence* focuses on signalling such violence and child abuse earlier and more effectively, and on stopping them for good to limit the damage they cause. *Divorce without Harm* aims to prevent harm to children as a result of their parents' divorcing or otherwise splitting up. The National Prevention Accord focuses on specific issues such as smoking and alcohol, which can also affect the first 1,000 days of childhood. The *Prevention and*

[27] The Dutch version of this programme mentions 14%. In the translation, this percentage was changed to 16.5%, due to the international use of new growth curves.

[28] Waelput, A. J. M. et al (2017). Geographical differences in Perinatal Health and Child Welfare in the Netherlands: Rationale for the Healthy Pregnancy 4 All-2 Programme. BMC, Pregnancy and Childbirth.

Support programme *for unintended pregnancies, including among teenagers* helps reduce the number of such pregnancies. Together, these action programmes constitute a comprehensive approach to preventing as many problems as possible and to addressing them as early as possible.
As this action programme was being developed, municipalities, professionals, public and private organisations, knowledge institutions and professional groups made active substantive contributions to it. Lessons from the approaches taken by municipalities such as Amsterdam, The Hague, Rotterdam, Tilburg, Utrecht and the Fen Communities were also examined.

The *Good Start* project, part of the *Fen Communities Opportunities Programme* focuses getting the next generation of Community residents off to a good start. It covers the phases between conception and eighteen years of age within a family. The project keeps track of parents and children, carefully assesses their need for care, and sets up an easily accessible care network. Each parent and each child has a number of contact moments with a healthcare professional. During these, they will look together at whether there is a further need for care in addition to the standard care that is offered. Should this be the case, they will be supported by a network of professionals. The *Good Start* programme works, among others, with *CenteringPregnancy*, *CenteringParenting*, and *Growing up Together*.

3. The approach: how we are going to achieve this

The national government, municipalities, health insurers, professional groups, interest groups and knowledge institutes are joining forces to bring about this action programme. If we make better use of and exchange our knowledge, experience and capacities, we can learn from each other. In this way, we will all be able to get more done and thus get vulnerable children off to a solid start. We will therefore organise this action programme based on local coalitions that are supported by a programme team and managed by a steering committee. In doing so, we will focus on three courses of action (see Chapter 4). To begin with, Sol*id Start* action programme has national goals, measures and results. At the local level, each municipality or region has its own goals, measures and results, which are tailored to the local situation and approved by the municipal council.

Building and anchoring *local coalitions* around the first 1,000 days is essential to a solid start for children in the municipality or the region concerned. These coalitions bring about end-to-end agreements between and among all organisations that have a role to play around the birth. In terms of their content, the chain agreements deal with the deployment of the most effective measures and, in practical terms, with the way in which organisations work together. The municipalities and regions themselves are responsible for building the local coalitions. In addition to the municipality, these coalitions include the most important local representatives of organisations, care providers, health insurers, youth healthcare and the professionals involved (members of neighbourhood teams, general practitioners, midwives, maternity-care workers, and gynaecologists). For their local approach, the coalitions can make use of and choose from the range of national measures. In this way, we also ensure that the national measures are firmly anchored in the municipal domain.

The action programme has a *national coalition* **of** intrinsically motivated people and influential opinion leaders. Together with the Minister, the coalition will promote the importance of the first 1,000 days and the implementation of Sol*id Start* action programme.

3.1 Building local coalitions

We want the chain to be redesigned at the local or regional level so that it focuses on the first 1,000 days of children's lives. In this way, we can reach vulnerable families more easily and provide them with better support. Redesigning the chain means that we will deploy youth healthcare at an earlier stage - that is, during pregnancy - and thus strengthen the connections between and among the medical, social and public-health domains.

Impetus for local coalitions

Together with municipalities, the action programme ensures that local coalitions adopt a coherent approach based around the first 1,000 days. This is in line with the Intergovernmental Programme, in which ambitions have been agreed regarding the most important topics for this legislative period. The Intergovernmental Programme also refers to the tasks of looking at health issues from a cross-domain perspective and establishing links between the medical and social domains, so that children get off to a good start. The government has made extra resources available for these social tasks in the Intergovernmental Programme. This gives municipalities the opportunity to form local coalitions - for example, around the first 1,000 days. For municipalities that are part of the Healthy in the City (*Gezond in de stad*, GIDS) initiative and that want to form a local coalition, funds will be made available under Sol*id Start* action programme by means of a decentralisation grant. Our aim is to achieve nationwide coverage by local coalitions. We will discuss with municipalities, municipal health services and healthcare professionals which agreements can be made in order to make the aforementioned measures a reality at the local and regional levels. Starting with the local coalitions, health insurers and municipalities will also have to come to agreements together about these first 1,000 days. If necessary, they can make use of the *Prevention*[29] *Coalitions* subsidy scheme. This scheme, which is part of the *Prevention in the Healthcare System* programme, helps municipalities and health insurers work together to provide comprehensive local aid and healthcare for particular vulnerable groups.

Several municipalities have already started approaches whereby local and regional coalitions work together around the first 1,000 days. In this programme, we are supporting this approach and disseminating lessons learned. These are the first local coalitions that we are envisaging, and that can serve as models for other Dutch municipalities:

- ***Healthy Pregnancy for All (HP4All)*** will be run intensively in seven GIDS municipalities, and will be rolled out to 165 other such municipalities in the coming years. Erasmus University Rotterdam has developed an approach in which obstetric care, maternity care, public healthcare, youth healthcare, district networks and other relevant partners work together in better ways at the district and neighbourhood levels. The GIDS municipalities involved are making this approach part of their municipal policy through the *Healthy in [...]* programme, with support from Pharos.

- ***The Safe, Healthy and Promising Start*** programmes will be run in seven other municipalities through Track 5 of *Reducing Health Inequalities* in the Social Domain Programme. Municipalities, health insurers, healthcare providers and professionals are jointly responsible for realising an integrated approach that offers vulnerable families a safe, promising and healthy start. The Netherlands Youth Institute and Pharos, which are knowledge partners, and the consultancy firm Andersson Elffers Felix are developing the training programme and offering substantive support. The learning and change track is getting funding from the Bernard van Leer Foundation.

- ***The Good Start programme*** is being run in thirteen municipalities in the Fen Communities. Under this programme, a number of municipalities in those Communities have set up an accessible healthcare network to address parents' needs for care. Working in group settings in accordance with *CenteringPregnancy*, *CenteringParenting*, and *Growing up together* means that vulnerable families in particular will be well served.

[29] Dutch Lower House of Parliament, 2016 - 2017 session, 32 793, nos. 213 and 249.

3.2 Figures for municipalities

With the help of a *perinatal atlas*, municipalities will soon be able to see where and in which neighbourhoods families whose children have an increased risk of getting off to a poorer start live. This atlas will contain key local, regional and national figures on health at birth, and will be completed by the end of 2018. In addition, starting in mid-2019 they will be able to make use of a *vulnerability atlas*, which will analyse the vulnerability of potential parents in Dutch municipalities and provide insights through local maps. These two atlases will serve as useful tools for municipalities to decide on the local approach they want to take regarding the first 1,000 days, as well as to monitor the progress they are making with their approach.
Nationally, there is a great deal of data on childbirth, but hardly any that can give us a picture of the health of children up to two years of age. In order to ensure that data on youth healthcare are made available at the national level, we will draw up a General Administrative Order. In this way, more information on the development of this age group in the Netherlands will be available at both the local and national levels.

3.3 A menu of interventions

To be able to offer vulnerable families appropriate support, it is important that municipalities know what effective interventions are in place, such as prenatal home visits, *Pre-Care*, *Starting Together* and *Sound Parenting*. We are therefore offering municipalities a menu containing an overview of the interventions that are available, the objectives of each, and the possibilities for funding. The menu will help municipalities make the right choices for the local approach they want on the basis of their figures.

3.4 Communication

Everyone should be aware of the importance of the first 1,000 days of a child, especially if it is vulnerable. Parents, professionals and municipalities have an essential role to play here. This makes them the main target groups for Solid Start action programme. We are focusing on these target groups through a multi-year national campaign. We are also looking at how we can use social marketing to bring about changes in behaviour. The Noaber Foundation, the Bernard van Leer Foundation, the Collaborative Health Foundations, and the Ministry of Health, Welfare and Sport will ensure that they coordinate their

3.5 Knowledge

Professionals need more information on the first 1,000 days. They need independent, scientifically substantiated knowledge, which is then transferred to the workplace so that they can actually start working with it. Together with the knowledge institutes, we will therefore develop a supportive knowledge programme for professionals in which we will collect existing knowledge, supplement it where necessary, and make it accessible to the professional field. We are also developing knowledge in programmes being run by the Netherlands Organisation for Health Research and Development (ZonMw) and the Netherlands Organisation for Applied Scientific Research (TNO) in order to realise the goals of Solid *Start* programme.

In addition, we are also making investments in expertise. We are engaging with professional organisations and training institutes to ensure that, already during their initial and further training, midwives, maternity nurses, youth nurses, general practitioners and professionals working in community teams become more aware of medical and social risk factors. This is about not only gaining knowledge, but also acquiring skills. Examples include being able to spot issues well and in a timely manner, to recognise light mental disabilities, and to spot poverty and/or debt, but also being able to support behavioural change in parents and prospective parents by having motivational conversations or starting conversations based around good health. We will also look into whether it is possible for young professionals from different disciplines to work together at the local level to disseminate knowledge in an interdisciplinary way about the first 1,000 days.

4. The courses of action

We will follow three courses of action to ensure that more children can get off to a solid start. In doing so, we want to achieve the following:

Course of action 1: **Before pregnancy**
- More vulnerable prospective parents will be well prepared when pregnancy begins.
- There will be fewer unplanned and unintended pregnancies in vulnerable families.

Course of action 2: **During pregnancy**
- There will be better identification of medical and social problems in parents and prospective parents who are vulnerable.
- More vulnerable prospective parents will get the help they need sooner.

Course of action 3: **After the birth**
- More vulnerable parents will be equipped for parenthood and raising children.
- Fewer babies and young children will be placed out of home or under supervision.

4.1 Course of action 1: Before pregnancy

In this course of action we want to help prospective parents who are vulnerable to become pregnant in a healthy way. In addition, we will help municipalities offer vulnerable parents the opportunity to discuss whether they are able to raise a child in view of their personal situation. The impact and consequences of pregnancy and parenthood and the possibility of contraception will be discussed in an in-depth discussion of this kind

4.1.1 Supporting vulnerable parents who would like to have children

We want vulnerable prospective parents to make a conscious choice to become pregnant. After all, children develop rapidly from the very beginning, so the health of the mother during pregnancy is crucial to their development. Not all parents--far from it--understand what is needed for a good start for their child. Or they may be in a situation that is getting in the way of a healthy lifestyle. When more parents start to think it is normal to talk to professionals about their wish to have a child now or in the future, parents about whom there might be concerns will also show up on the radar. Several municipalities already offer consultations that prospective parents can go to with their questions. In practice, however, it appears that few

vulnerable parents actually make use of this: we are not reaching the very group of parents that this is all about. That is why we are aiming for better outreach to vulnerable prospective parents. We will do this in the following ways:

- ***Healthcare prior to conception***
  Local coalitions will experiment with discussing the wish to have children based on the needs of vulnerable parents. Together with municipalities and professionals, we are investigating how vulnerable parents who want to have children can be reached more effectively: how parents prepare themselves for the decision to have children, what motivates parents to talk--or not--about their wish to have children, and how we can include such conversations in regular contact moments in the context of healthcare for youth. In this connection we will be taking into account the results of the projects run by the Netherlands Organisation for Health Research and Development (ZonMw) on healthcare prior to conception and the results of *the Healthy Pregnancy 4 All Programme*.

- ***Training***
  Youth healthcare professionals are trained to talk to vulnerable parents about their potential wish to have children.

- ***Learning sessions***
  We want to translate into working practice the experiences of the local coalitions with outreach to vulnerable parents. To this end, we are organising learning sessions with municipalities.

4.1.2 Making Not Pregnant Now available nationwide

Unplanned and unintended pregnancies are a particular problem for women who are homeless, in the Netherlands illegally, mentally disabled, addicted, socially isolated or mentally burdened. Their situation often leads to complicated pregnancies, prenatal harm, postnatal supervision or, finally, placement out of home. *Not Pregnant Now* is a successful local project that has been developed in Tilburg. It works against vulnerable parenthood in this specific target group through in-depth conversations that take place on a voluntary basis, with a proactive approach tailored to the needs of the individual. It is about raising awareness of their situation and discussing sexuality, contraception, and the consequences of pregnancy and parenthood. Following participation in the programme, many women voluntarily opt for long-term contraception. These women are usually already on the radar at several healthcare institutions such as abortion clinics, mental-health institutions, youth institutions, institutions for the homeless, gynaecologists, midwives, general practitioners and other care providers who work with vulnerable people. The strength of *Not Pregnant Now* lies mainly in its personal approach and in the cooperation it fosters among various institutions. Care providers receive training so they can integrate conversations about the wish to have children and the use of contraception into their day-to-day activities. The approach is embedded in the municipal offer of assistance. . Research is now being done through the Netherlands Organisation for Health Research and Development (ZonMw) into the effectiveness of *Not Pregnant Now*. In order to help vulnerable women to choose not to become pregnant now in their specific situation, we will offer *Not Pregnant Now* to municipalities nationwide. We will do this in the following ways:

- ***Nationwide support for Not Pregnant Now***
  We will offer financing through the Intraregional Medical-Assistance Organisation to make Not Pregnant Now available to municipalities so that it can become part of the municipal infrastructure. They will support the municipal health services by temporarily compensating local project leaders, the national programme team and its quartermasters, and by providing the required means of communication and registration. As Not Pregnant Now is fleshed out further and rolled out, specific attention will be paid to criteria for access to the programme and to quality criteria in its implementation. We will establish criteria for determining which women should or should not be supported in the project.

- ***Implementation of Not Pregnant Now projects in central municipalities***
  For each region, we will look at the practicable scale we want for setting up and rolling out a Not Pregnant Now project. We will then implement each project in the region on a tailor-made basis, possibly setting up several of them in each central municipality.

4.2 Course of action 2: During pregnancy

Parents who are vulnerable experience stress because of a variety of problems having to do with education, housing, debts and/or a limited social network. In this course of action, we want to be quicker to identify problems with vulnerable prospective parents. In addition, we want to support, as soon as possible, vulnerable parents who are already pregnant, so that their children can be born as healthy as possible and receive the care they need after birth. We will do this by taking the following measures:

4.2.1 Getting a clearer picture of vulnerable households

Social risk factors such as living conditions, stress, and lifestyle cause children problems later in life. Professionals thus need to be alert to these factors. The sooner they can spot these red flags in vulnerable families, the sooner they will be able to provide the right support. However, such risk factors do not always show up on professionals' radars, because they are not surveyed systematically. That is why we are ensuring that, in future, maternity care and youth healthcare services will use warning mechanisms that will also flag social risk factors. We will do this in the following ways:

- ***Dissemination of warning mechanisms***
  We will identify all the warning and risk-assessment mechanisms related to medical and social-risk factors. We will actively disseminate these to professionals working in obstetrics and healthcare for youth. We will also make agreements with local coalitions so they can use these particular warning mechanisms.

- ***Notification of at-risk pregnancies***
  We will make agreements with professionals such as general practitioners, gynaecologists, midwives, and adult mental-healthcare and addiction-healthcare professionals whereby, with the patient's consent, they will report to healthcare for youth or the neighbourhood team that their high-risk patient is pregnant, so that the right support can be provided in good time.

4.2.2 Earlier assistance for vulnerable families

Worrying conditions for children may already occur during pregnancy. There may also be signs during this time that such conditions could arise. Vulnerable parents are often already known to social services, such as healthcare services for addiction. In order to get a better picture of these families in the case of the wish to have a child or of an actual pregnancy, it is important that obstetrics and healthcare for youth services work together actively in the best way, exchange information about vulnerable families, and have good connections with other healthcare institutions.[30] Only then will healthcare for youth be able to provide timely help and make a start on tackling existing problems. In this way, we can obviate the need for more-intensive help at a later stage. Moreover, this approach provides health benefits for both parents and children. That is why we want vulnerable families to get help more quickly. A good exchange of information among professionals working in obstetrics and healthcare for youth is essential for this. In order to achieve this, there is a process within obstetrics, but outside this programme, known as BabyConnect. We will also do this by taking the following steps:

- ***Prenatal home visits***
  Vulnerable families will receive intensive guidance during pregnancy from the youth healthcare system. This can start with a prenatal home visit intended to determine what help or care is needed in the family. Such a home visit will be in line with the trend whereby the contact moments in the context of healthcare for youth are flexibilised. There will be more attention for families who need it, and less if everything is going well. In order to make it possible for the youth healthcare system to support these vulnerable parents *before* the birth of their child, the Public Health Act will be amended.

- **Chain agreements on multidisciplinary cooperation**
  Local coalitions will make chain agreements with those working in obstetrics and healthcare for youth regarding good cooperation with the obstetrics partnerships, for example through the participation of healthcare for youth in obstetrics partnerships and/or the formation of multidisciplinary teams. The timely referral of vulnerable families is paramount. The Royal Netherlands Organisation of Midwives guide entitled *Vulnerable Pregnancies* can be used here.

[30] The Healthcare and Youth Inspectorate (2017). *Active youth healthcare services.*

- ***Cooperation around vulnerable families***
  Those working in obstetrics and parties in the social domain, including healthcare for youth, will cooperate intensively around pregnancies in vulnerable families. The focus will be on flagging problems effectively, having a strong referral system, and providing optimal support before and during pregnancy, and after the birth of the child.

4.2.3 Professional roadmaps/care pathways

Vulnerable families often need a helping hand. There are several successful approaches that offer just that, and that thus contribute to getting children off to a better start. For example, there are several effective interventions aimed at parents who are expecting a child. These range from general group courses such as CenteringPregnancy and short-term interventions such as *Sound Parenting* for pregnant women who need special attention, to *Pre-Care*, a two-and-a-half year process within youth healthcare for highly vulnerable pregnant women. There are also interventions for parents after the birth of their child, such as video home training. In order to be able to adequately deploy interventions that are tailored to the care that the pregnant woman needs, professionals need to know which steps can be taken in relation to any kinds of issues. Since the use of roadmaps or care pathways can provide insights here, we will ensure that professionals in municipalities can make use of local roadmaps. We will do this in the following ways:

- ***Sample roadmaps/care pathways***
  We will develop examples of roadmaps for municipalities.

- ***Composition of local roadmaps/care pathways***
  We will support municipalities in putting together their local roadmaps on the basis of the examples and of the selections they make from the menu. With these roadmaps, professionals can quickly deploy the right offer of help and support to vulnerable families.

4.3 Course of action 3: After the birth

However much attention there is now for parenting support, too often vulnerable families receive support too late or not at all. They go off the rails and need to appeal for more intensive care. In the worst-case scenario, the child is harmed without even having been in the picture. It is estimated that only a third of vulnerable parents seek help or advice in their upbringing. In this course of action, we want to offer *earlier* and *well-targeted* help and parenting support to vulnerable parents. We want them to be better equipped for parenting and child-rearing, and to have a safety net to fall back on. We will do this by taking the following measures:

4.3.1 The flexible use of contact moments in youth healthcare

Youth healthcare sees all young children and their parents frequently during the first years of the children's lives. This includes vulnerable families, who benefit from more time and attention than is available through the regular contact moments. We want municipalities and professionals to use the contact moments more flexibly than is currently the case, so that children and families at risk receive the support they need. Among the ways to do this would be a longer consultation, a home visit, or the provision of extra information. As a result, contact moments for subsequent children in less vulnerable families could be less frequent. Flexibility creates a greater focus on vulnerable families, so that they do not need more help at a later stage. Local coalitions can already use the flexibilisation of contact moments by experimenting. We will also do this by taking the following steps:

- ***Customer roadmaps***
  Youth healthcare will map out the customer journey for all clients on file. On the basis of this customer roadmap, they will determine which parents and children need more support, and which ones less. We will actively disseminate these customer roadmaps through learning groups and regional meetings.

- ***Profiles***
  In addition to customer roadmaps, we will use profiles to initiate flexibilisation and extra customisation for vulnerable families. These family profiles will be created by combining and visualising existing data on different aspects of people's lives, such as lifestyle, income and network.

4.3.2 *Accessible parenting support for vulnerable parents*

To give children a good start, sensitive parenting is essential. But it can be quite a challenge for vulnerable parents in particular to sense what their child needs and to act accordingly, for instance because they are less familiar with this from their own upbringing, or simply because they have too many worries on their mind. That is why it is especially valuable for these parents to have someone who can listen to the parenting questions they have to face, and offer practical tips or just share in their concern. Group discussions, such as with CenteringParenting, are a form of accessible parenting support. We believe it is important for municipalities and professionals to help vulnerable families with parenting. Different target groups each need their own approach: a parent with a mild mental disability needs a different form of help from a highly educated parent who is feeling stress or who has mental health problems. We will do this in the following ways:

- ***Learning groups***
  We will actively disseminate knowledge among municipalities and professionals about good examples of support for parenting intended for vulnerable parents. We will set up learning groups to anchor these examples in municipalities.

- ***Training in interviewing***
  Youth healthcare professionals will receive training in interviewing to proactively engage in discussions with parents about parenting challenges.

- ***Group discussions***
  Municipalities and professionals will organise group discussions for vulnerable parents. Parents will be able to exchange parenting questions and learn from each other. At the same time, participation expands their social network.

- ***Digital platform***
  Public and private entities will develop a digital platform for parents. Parents will be able to go there for advice and information from youth-healthcare organisations and find links to reliable websites such as opvoeden.nl, which offers advice on rearing children.

4.3.3 *Supporting very young vulnerable parents*

When teenagers and people in their twenties have a child, a lot of problems often come up at the same time. Examples include problems with housing, income, education, childcare and work. These very young vulnerable parents sometimes need intensive support, both during pregnancy and after the birth of their children. Because of the complex nature of these problems, it is important that this guidance be aligned with practical assistance in such areas as housing, work and education. With the Youth Act, the Social Support Act, and the Participation Act, municipalities have many opportunities to offer these very young vulnerable parents solutions tailored to their needs. Unfortunately, in practice this does not happen as much as it should because municipalities sometimes do not have enough theoretical or practical knowledge to provide the right kind of support to these young parents. That is why we are going to support municipalities in this effort. We will do this in the following ways:

- ***Programme line***
  Based on the transformation agenda put out by Young Parenting and Unintended Pregnancy, the Netherlands Organisation for Health Research and Development (ZonMw) is developing a programme line in which it inventories and broadens existing knowledge and information about parenting for young and very young parents. Those working in the field and municipalities can carry out experiments to gain experience together with an integrated approach to parenting on the part of young and very young parents.

5. Progress and results

Monitoring

We will give Solid *Start* programme all the attention it needs by setting goals that are as specific as possible. We will *monitor* the results of the action programme in order to get an indication of the level of impact it is having. We want to make sure that fewer children get off to a poor start. We will measure this on the basis of the percentage of children who are born prematurely, who are underweight at birth, or both. We also want to know how young children develop in the first two years after birth, so that we have a better view of their development during the first 1,000 days of their lives. That is why, with this programme, we are also aiming to develop a new indicator that also takes into account the health score of children at two years of age. This indicator will consist of a combination of the percentage of children who are born prematurely, who are underweight at birth, or both, and the health score at two years of age. Finally, we will also monitor how many children are the subject of a child-protection measure - that is, who have been put under supervision or with a guardian. In this way, this action programme will provide valuable information to be used as guidance on the first 1,000 days of children's lives, at both the local and national levels. In order to be able to determine the health score at two years of age, we will make available data on youth healthcare at the national level. In this way, more information on the development of this age group in the Netherlands will be available at both the local and national levels. We will monitor all health outcomes in combination with the birth figures.

Process indicators

In addition, we will map out a number of *process indicators*, with which we will first monitor the progress of implementation and then measure the results of the action programme. We have opted for the following process indicators:

- The number of municipalities that offer pre-conception care through the youth-healthcare service and general practitioners, among others.
- The number of municipalities where *Not Pregnant Now* has been implemented or where implementation has started, as well as the reach of this programme.

Experiencing, doing and learning

We will present the results of the national measures and the local coalitions in various ways. We will use a wide range of communication tools for this purpose. The national coalition can also play a role here. This will involve *a combination of storytelling, experiences, facts and figures*. The action programme will last about three years. An evaluation will take place in 2021. On the basis of this, we will decide whether to continue with Sol*id Start* programme and, if so, how.

6. Financing

The amount available for the implementation of this action programme is € 41 million for its duration (2018 - 2021). Some foundations, including Bernard van Leer, are willing to help invest in its implementation, wherever the action programme is

Dit is een uitgave van
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