



Robert Wood Johnson Foundation

Children and Society: A Global Scan of Child Well-Being

Submitted to the Robert Wood Johnson Foundation

AUGUST 2019

Scott Pulizzi, PhD | Angelica Herrera, PhD | Shaylyn Quinn | Brenda
Ramirez | Deborah Moroney, PhD

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Executive Summary

The purpose of the study is to investigate the issue of child well-being from different national contexts and to identify implications for programs and policies in the United States. Children will be in a better position to reach their full potential when their well-being is prioritized by their families and communities. We define well-being as the constellation of the physical, psychological, cognitive, social, and economic domains that come together holistically. Well-being is increasing in importance and profile, for example the Organization for Economic Cooperation and Development's Better Life Index uses sectoral indicators (e.g., health, education, housing) to measure well-being across its member countries. However, we contend that well-being is more than the collection of indicators. The different domains mutually reinforce one another. While there are exceptions, such as the 2019 national well-being budget proposal of New Zealand, most programs are focused on sector outcomes, without an explicit aim of holistic child well-being.

In this study, we asked the question: *How can a holistic concept of child well-being be advanced?* We looked at examples of programs and policies that contribute to child well-being from six national contexts to provide insights. The issues we investigated include **early childhood education in Australia, childhood obesity in Brazil, youth tobacco misuse in Canada, public education in Finland, youth suicide in Japan, and breastfeeding in South Africa**. We investigated how the government framed the issue, the motivation for response, rationale for public action, strategies to change norms, and entry points to promoting well-being beyond the program. We did not investigate each country's performance on separate indicators. We did not evaluate the programs in terms of their stated objectives and effectiveness as stand-alone interventions. Rather, we looked at what can be learned from these examples to inform how to promote well-being holistically and to create a culture of health.

We gained insights into how to promote well-being as a holistic concept, which all support a culture of health. This includes the effect of income inequality on well-being, how shared values can form the basis for collective action, strategies to change norms, and the opportunity to capacitate citizens for action. We draw 12 implications that can inform policies and programs in the United States to promote child well-being, some of which can be acted on immediately, while others require a long-term strategy. The 12 implications for planners are the following:

1. Address the causes and effects that income inequality has on child well-being.
2. Promote rights-based approaches to child well-being and emphasize values such as equity, inclusion, and social responsibility.

3. Raise awareness on the ecology of well-being: how the systems, conditions, and our personal interactions affect one another in different ways.
4. Design programs that increase everyone's understanding of their environment, historical inequities, and the norms that influence behaviors; and, demonstrate how individuals can contribute to child well-being.
5. Explain how the benefits of child well-being can ramify across one's own lifespan and across society generally.
6. Understand how norms are changing because of society-wide forces and appreciate, and respond to, the effect they have on individuals, families, and communities.
7. Promote a counter-narrative to the atomized individual – one rooted in justice and compassion – on the public policy agendas of different levels of government.
8. Use well-being as the unifying objective for cross-sectoral collaborations to break down silos between agencies, disciplines, and other stakeholder groups.
9. Utilize new methods and technologies that afford individuals and groups the chance to contribute to the collection and use of information that affects their lives – and provide appropriate capacity development so that marginalized persons have equitable opportunities to contribute.
10. Create new epistemologies for well-being: measure programs on longer time frames, as programs become more holistic, they may take longer to show results; develop metrics that go beyond the narrow measures of single conditions and simple binaries; prioritize developing methods to collect subjective measures of well-being for a wide age range of children so that their voices are represented.
11. Convene experts and stakeholders across disciplines who can contribute to more holistic thinking on child well-being, by developing frameworks, action plans, evidence, and tools.
12. Designate authorities with the mandate to work across public administrative sectors to coordinate efforts, harmonize approaches, and employ resources effectively for the benefit of child well-being.

We used extant data, which allowed us to research the current national context but limited our ability to measure difference within country and to gain a greater understanding of the social, political, and historical factors that affect child well-being. Still, from the literature we reviewed and the case examples we studied we were able to develop a theory of change:

If more people are inspired to think holistically, have the capacity and opportunity to engage in change, are driven and supported by values and norms that contribute to a healthy and equitable society, then child well-being will be a realized American value.

Introduction

The purpose of this study is to understand child well-being in select countries and to identify implications for work in the United States. Child well-being is strongly connected to short- and long-term outcomes, including educational attainment, earnings and employment, health, positive parenting, and degree of community engagement (UNICEF, Office of Research, 2013). The well-being of children and their families is influenced by complex factors that contribute to or hinder well-being. How countries view and position children and their families in society, as well as how they define well-being, has changed over time. National governments are moving to measure well-being not just in terms of economic growth but also to include indicators of child and family well-being (Stiglitz Commission, 2009).

All children deserve to be happy and healthy and live in environments that are safe and stable and that nurture their unique skills, competencies, and potential. The umbrella term of well-being includes happiness, health, and other domains. For this project, our working definition of *well-being* is informed by Pollard and Lee (2003), who conducted a systematic literature review and found that, although definitions of well-being differ across disciplines, five domains are critical to conceptualizing children's well-being holistically. These domains are physical, psychological, cognitive, social, and economic. Although this typology remains useful, we know that the five elements are dynamically and ecologically related (Blum, Bastos, Kabiru, & Le, 2012; Lerner et al., 2018; Overton, 2015). Similarly, the United Nations Convention on the Rights of the Child (Office of the High Commission at the United Nations, 1990) promotes a holistic view of child well-being, giving equal weight to children's civic, political, social, economic, and cultural rights, and emphasizing that these rights are interrelated, universal, and indivisible (Ben-Arieh, 2009).

Through this study, the American Institutes for Research (AIR) team builds on the vision of the Robert Wood Johnson Foundation (RWJF) Healthy Children, Healthy Weight and Global Ideas for U.S. Solutions portfolios. The objective of the study to explore well-being strategies from six countries that may be transferable to the United States. We investigate how well-being issues are framed by government, how values and rationale for action are expressed, and how norms change is addressed.

This research project is different from many cross-national comparative studies in that we did not examine or compare countries' performances on indicators of child well-being, such as done through the Organization for Economic Cooperation and Development's (OECD's) Better Life Index (OECD, 2017a) or the Global Youth Development Index (Commonwealth Secretariat, 2016). Instead, our aim is to investigate child well-being as a holistic concept. Many measures of programs that support well-being are largely the sum of interventions addressing singular

issues, such as in education or health. In this study, we draw on examples of interventions, programs, and policies from six countries (Australia, Brazil, Canada, Finland, Japan, and South Africa) to understand how priority issues are addressed and to identify entry points to a more holistic concept of child well-being. We accomplish this aim by investigating values, norms, and strategies to effect change that underpin national responses to priority issues. We explore a range of these issues that affect children’s well-being through several developmental periods, including infancy, early childhood, middle childhood, adolescence, and young adulthood. In addition, the six countries in our sample represent geographic diversity and the range of relative rankings on OECD’s Better Life Index.¹

Method

The AIR team conducted an extensive literature review of governmental documents, peer-reviewed journal articles, books, program reports, and websites. In addition, we convened an advisory group consisting of methodological and content experts, across disciplines and representing government, academia, civil society, and multilateral agencies, to guide us in the study. We consulted with experts we met at the Salzburg Global Seminar on Healthy Children, Healthy Weight.² To ensure the findings from the country cases are accurate, in-country experts reviewed and provided feedback on each of the country case examples in this report. For a complete description of our methods and the profile and role of the advisory group, please see Annex.

To understand the context of children’s well-being, we investigated the political operationalization of values used to explain and legitimate specific public policies or interventions. Values, at the individual level, are subjective views about what is worthy and important. We drew inspiration for this approach from an article about the Canadian universal health-care system that stated, “public statements of shared values may serve as important guides to action” (Marmor, Okma, & Latham, 2010). The government’s response to a well-being issue—that is, how it justifies a program and expenditure to the public—provides insight into a country’s values related to children’s well-being.

Social norms inform individual and social behavior, which makes them important to study because norms can promote or hinder child well-being. Social norms can be understood as “constructed by one’s beliefs about what others do, and by one’s beliefs about what others think one should do” and are maintained by social influences (Mackie et al., 2015). According to research by Bicchieri and Mercier (2014), norms change when the empirical (what will happen) and normative (what ought to happen) expectations of individuals change within a social group.

¹ For more details, please see <http://www.oecdbetterlifeindex.org>

² For more information on the seminar, see <https://www.salzburgglobal.org/news/latest-news/article/healthy-children-healthy-weight-making-an-impact.html>

Changes can be sustained when they are reinforced by people whose feelings and/or opinions and/or power matter to us and if individuals perceive that others are likely to uphold the change and that the consequence of sanction is valid. In the chapters that follow, we examine norms in relation to the governmental responses to particular child well-being issues. Given the foundation's interest in social norms change, we conducted a literature review on social norms that went beyond the six countries highlighted in this report. Please see Annex for the findings from that literature review.

Structure of the Study

This study is organized into 8 chapters that include the examples from six countries and conclusions that draw implications for well-being programs in the United States.³ We also discuss the limitations of the study and recommendations for further exploration. This study is not an evaluation or review of programs on technical merit or efficacy, such as whether the program reduced obesity. Our analysis centered on the government response to the following well-being issues that demonstrate examples of how to move toward a more holistic vision of well-being, beyond the single issue of inquiry:

- Early childhood education in Australia
- Childhood obesity in Brazil
- Youth tobacco use in Canada
- Public education in Finland
- Youth suicide in Japan
- Breastfeeding in South Africa

The RWJF aims to move from *me* to *we* in support of a culture of health. Through the investigation of these national responses, we discover several different strategies from different contexts that may be applied in the U.S. context to advance the culture of health in support of child well-being.

³ For more information on conditions in the six countries, please see the Annex.



Findings

Early Learning in Australia

In this chapter we explore how Australia addresses children's well-being through its approach to early childhood education. We begin by describing Australia's population and education system. Then, we discuss the approach to early childhood education and the development of the National Partnership Agreement (NPA) on Universal Access to Early Education. We explore the values and norms underpinning the NPA; the Early Years Learning Framework (the national curriculum for early learning); and The Nest action agenda, a national plan aiming to improve child and youth well-being. We end this chapter by examining the response to Australia's early childhood education system and the implications of Australia's approach to early childhood education for well-being initiatives in the United States. The objective of this chapter is not to present an extensive history of early childhood education in Australia or the United States nor to conduct an in-depth analysis of both countries' early childhood education policies. Our aim is to gain insight from Australia's approach to children's well-being via its early education system. RWJF, American policymakers, and advocates can learn from this example on changing social norms by advancing universal access to early childhood education.

Population and Education System

Australia is the sixth-largest country in the world by total area and has a population of almost 24 million people. Children and youth comprise about a quarter of its population, totaling almost 6 million children and youth between the ages of 0 and 19. The national language is English. The population is diverse and 28% are foreign born. Aboriginal and Torres Strait Islanders peoples were 3% of the total population in 2016. Most Australians live in urban areas and are concentrated on the eastern seaboard.

Australia outperforms other OECD countries on several educational indicators, for example, the average score among Australian youth was 0.93 in the education domain⁴ of the Youth Development Index, significantly higher than the average global score of 0.71. Primary and secondary school in Australia is free, and compulsory schooling ranges from age 5 to 15 or 17 years old, depending on the state of residence, with the average duration of education enrollment being 21 years. School enrollment starts early, and rates are relatively high across age groups. In 2014, 35% of children 0 to 2 years old, 69% of 3-year-olds, and 85% of 4-year-olds were enrolled in formal early childhood education (Early Learning: Everyone Benefits, 2017; OECD, 2016). The participation of young children in Australia's formal early childhood education is higher than some OECD countries. For example, the rate of 3-year-olds enrolled in early childhood education in the United States in 2014 was 42% (OECD, 2016). The relatively

⁴ The education domain is composed of the following indicators: total (gross) enrollment in secondary education, any age, as percentage of population of official secondary education age, percentage of 15- to 24-year-olds who can both read and write with understanding a short simple statement on everyday life, and percentage of 15- to 24-year-olds with 5 years or more of experience using the internet (Commonwealth Secretariat, 2016).

high participation rates in early childhood education in Australia are a recent phenomenon. In 2005, just 17% of 3-year-olds and 53% of 4-year-olds were enrolled in formal early childhood education (OECD, 2016).

Universal Access to Early Childhood Education

The gains in the past decade in the participation of 4-year-olds in early childhood education (ECE) appear to be due to the Australian government's NPA on Universal Access to Early Education, a funding commitment developed in 2008 that ensures universal access to a quality preschool program (also referred to as kindergarten in some states) for all children in the year before full-time school (Early Learning: Everyone Benefits, 2017; see sidebar). This agreement

Objective of the National Partnership Agreement on Universal Access to Early Education

"The objective of the universal access initiative is to provide universal access to quality preschool programs for all children in the year before full-time school for 600 hours per year, delivered by a qualified early childhood teacher who meets National Quality Framework (NQF) requirements, with a focus on participation by Indigenous and vulnerable and disadvantaged children. Preschool programs are play-based and tailored to meet the learning needs of younger children. They are delivered in accordance with the Early Years Learning Framework, which has been developed by experts and agreed by all Australian governments. Programs must be delivered in a way that meets the needs of children, parents and communities and ensures that cost is not a barrier to participation"
(Australian Government Department of Education and Training, 2013–2014).

committed the Commonwealth and all state and territory governments to achieving universal access to preschool by 2013 (Baxter & Hand, 2013).

The push for a national commitment to universal access to ECE began in 2006 when the Council of Australian Governments committed to improving early childhood development outcomes as part of a collaborative national approach. The commitment was based on international research that shows the benefits of ECE for later life outcomes, especially for disadvantaged children (Harrington, 2014). A universal approach to ECE is widely regarded as an effective way to increase young children's participation in ECE because it is non-stigmatizing and influences social norms related to children's participation in and community support for early education (Early Learning: Everyone Benefits, 2017). Because families of all backgrounds benefit from universal access, ECE in Australia has broad political approval and support from middle-class and affluent families with political and social capital (Early Learning: Everyone Benefits, 2017; Melhuish, 2015).

ECE can result in positive short-term and long-term outcomes only if the program is of high quality (Campbell et al., 2014). The Council of Australian Governments recognized that a commitment to universal access to ECE needed to include a focus on quality. In 2009, the NPA developed the National Quality Framework (NQF) for Early Childhood Education and Care, which includes a national law for ECE, regulations, standards, learning frameworks (one for early learning and another for school-age care), and assessment and rating processes (Australian Children’s Education and Care Quality Authority, 2018). The Australian ECE system operates in a federated governmental structure, with monitoring and compliance of the NQF being the responsibility of states and territories. All approved ECE providers must adhere to the NQF and use the *Belonging, Being & Becoming: The Early Years Learning Framework for Australia* or Early Years Learning Framework. The Charles Sturt University-led Consortium developed the framework. The consortium members included academics, service providers, representatives from early childhood organizations, practitioners, and consultants (Sumsion et al., 2009).

**The Council of Australian Governments’
Vision for Children’s Learning**

“All children experience learning that is engaging and builds success for life. Fundamental to the Framework is a view of children’s lives as characterized by belonging, being and becoming. From before birth children are connected to family, community, culture and place. Their earliest development and learning takes place through these relationships, particularly within families, who are children’s first and most influential educators. As children participate in everyday life, they develop interests and construct their own identities and understandings of the world”

(Belonging, Being & Becoming: The Early Years Learning Framework for Australia, 2009, p. 7).

Well-Being at the Center of Early Learning

The Early Years Learning Framework in Australia is focused on whole-child development for children ages 0 to 5. The purpose of the framework is to improve the conditions for learning for young children with a holistic well-being and developmental approach. The framework recognizes that belonging, being, and becoming are key to children’s well-being and healthy development:

- Belonging is defined as knowing where and with whom you belong and integral to human existence. “Children belong first to a family, a cultural group, a neighborhood and a wider community . . . Belonging is central to being and becoming in that it shapes who children are and who they can become.” (Belonging, Being & Becoming: The Early Years learning Framework for Australia, 2009, p. 7).
- Being is the “here and now” and recognizes that childhood is a special time in which children are seeking and making meaning of the world.

- Becoming recognizes that children’s identities, knowledge, understandings, capacities, skills, and relationships change during childhood and are shaped by events and circumstances. Becoming reflects this process of rapid and significant change that occurs in the early years as young children learn and grow. It emphasizes learning to participate fully and actively in society (Belonging, Being & Becoming: The Early Years Learning Framework for Australia, 2009).

A supplementary aim of the framework is to close gaps in educational achievement among Aboriginal and Torres Strait Islanders peoples and non-first peoples in Australia. The framework endeavors to achieve its vision through the following five principles:

13. Secure, respectful, and reciprocal relationships
14. Partnerships with families
15. High expectations and equity
16. Respect for diversity
17. Ongoing learning and reflective practices

It is expected that teachers will apply the five principles in their daily work. The framework includes learning outcomes such as “children develop knowledgeable and confident self-identities” and gives teachers examples of behaviors that teachers can observe and practices that lead to the learning outcomes, such as “acknowledging and understanding that children construct meaning in many different ways.” The framework marks a departure from ECE tradition in Australia because it emphasizes intentional teaching, play-based learning and child development, outcomes, and equity (Grieshaber, 2010). The framework rollout was accompanied by teacher support materials, a communities of practice platform, training videos, and social media groups (Council of Australian Governments, 2009).

The interest in child well-being in Australia has grown beyond the Early Years Learning Framework. In November 2013, The Nest action agenda was released at the national Parliament House with tri-partisan support.⁵ The agenda, facilitated by the Australian Research Alliance for Children and Youth (ARACY) in collaboration with Bupa Health Foundation, prioritizes evidence-based programs to improve the well-being of children and youth 0–24 years of age and includes operational principles to mobilize collective efforts to achieve well-being. The Nest builds on existing frameworks and programs and bridges gaps between them (ARACY, 2014). The Nest action agenda resulted from a cross-sectoral collaboration of leaders from government, research, education, service organizations, and children and youth who were

⁵ <https://www.aracy.org.au/projects/the-nest>

all motivated by a belief that Australia should be the best place in the world to be a young person (ARACY, 2014). The action agenda has ambitious targets: Australia to be in the top five OECD countries by 2025 for educational performance, physical well-being, social and emotional well-being and participation in issues affecting young people and focuses on six outcomes (being loved and safe, having material basics, being healthy, learning, participating, and having a positive sense of identity and culture). These outcomes are applicable to all Australian children and youth, regardless of age, gender, ability, ethnicity, race, and socioeconomic status.

The Nest Action Agenda Operational Principles

A commitment to:

- the child at the center;
- privileging Aboriginal and Torres Strait Islander knowledge;
- a long-term, evidence-informed approach;
- prevention and early intervention;
- a life-stage approach; and
- systemic change using an outcomes approach

(ARACY, 2014)

In reviewing the language from the Early Years Learning Framework and The Nest action agenda, we can see values are explicitly stated through the principles on which both documents are based, including social inclusion and cohesion, equity, ethical responsibility, and lifelong learning. The Early Years Learning Framework also suggests that respecting the multiple ways of knowing, seeing, and living, as well as celebrating diversity, are ways that teachers practice inclusivity. A critical

value embedded in the framework is the recognition that early childhood education must address whole-child development and focus on children’s well-being, which is enriched by experiences and conditions in ECE that are holistic and connect mind, body, and spirit. The Early Years Learning Framework also values context (family, community, and place). The framework provides a call to action that is based both on children’s rights and on the economic benefits of ECE to the country. The Nest action agenda builds on the economic benefits argument by linking children’s health to the nation’s economy: “. . . healthy children mean a healthy economy” (ARACY, 2014, p. 4).

Through the lens of well-being, we see that Australian policymakers value individual development in a social context. The Council of Australian Governments made a powerful argument in favor of ECE that emphasized the connection between ECE and positive outcomes by claiming that Australia is stronger when children can reach their potential and that early learning is the foundation. This example from Australia demonstrates how to address well-being in the early childhood stage of development, how to establish healthy relationships between children and teachers and staff, and how to provide a rationale for action that is mutually beneficial to individuals and the nation.

Response to Australia’s Approach to Early Learning

The universal ECE program in Australia has broad support across political parties and groups. Many Australians value the notion of giving everyone “a fair go” and see improving their early childhood education system as a way to better live up to this principle (Tayler, Peachy, & Healey, 2018). The current party in power, the conservative Liberal Party, is in favor of the current NPA and has committed to funding universal access to ECE for 4-year-olds (Karp, 2018). The opposition Labor Party made extending the Australian ECE program to 3-year-olds a component of its platform in the May 2019 election, which was won by the conservative party. Both parties in Australia are in favor of universal access of ECE; however, they have different views regarding dosage (how many hours per week) and age of entry. The Labor Party argued that children should enter ECE at age 3 because of research showing 2 years of ECE can close gaps created by disadvantage and tackle inequities due to socioeconomic status (Murphy & Karp, 2018).

Australian families’ attitudes regarding access to ECE vary, depending on the barriers and supports involved in their own children’s participation in ECE (Baxter & Hand, 2013; Hand, Baxter, Sweid, Bluett-Boyd, and Price-Robertson, 2014). A qualitative study of 94 families in Victoria, South Australia, Western Australia, and Tasmania found most families had used and valued ECE and believed ECE prepares children for school and develops children’s social skills (Hand et al., 2014). The authors examined whether different models of delivery affected views of access. Where ECE was offered through schools, there was universal acceptance of ECE (Hand et al., 2014). Families who used other delivery models also expressed positive views of ECE, although they mentioned needing to “shop around” to find the ECE program that best suited them in terms of hours of availability, location, and costs (Hand et al., 2014). Other research shows that children’s participation in Australia’s ECE is also related to location (remote areas have lower participation rates than urban areas); socioeconomic status (there are higher participation rates in more advantaged areas, although “moderate” advantage had lower participation than the most disadvantaged areas); and demographic characteristics, with lower participation among Aboriginal and Torres Strait Islanders children, children from non-English-speaking backgrounds, and children with special health-care needs compared with other children (Baxter & Hand, 2013).

Implications for Well-Being Initiatives in the United States

Similar to arguments made in the United States in favor of ECE, political parties in Australia tend to frame the argument in terms of economic costs and benefits. Experts argue that investing in ECE will lead to economic returns over a child’s life that will be reflected in higher earnings and workforce participation; increased tax revenue; and considerable savings in health, education, and justice budgets (The Front Project, 2019). This argument also includes a focus on revenue created by parents’ participation, especially mothers’ participation, in the workforce (Melhuish, 2015).

While Australia offers universal access to high-quality ECE for all 4-year-olds, the United States has a mixed-delivery system, in which ECE services are funded by the federal government (Head Start, Early Head Start, IDEA Preschool Grant, Preschool Development Grant), state and local governments, or by private organizations or family fees. Some programs, such as Head Start and Early Head Start, and some state and local preschool programs are targeted to children with certain family characteristics (e.g., low income, parent is in the military, family lives in a specific area or neighborhood) (Muenchow & Weinberg, 2016). Only three states—Florida, Georgia, and Oklahoma—have truly universal programs, in that the programs are available to all 4-year-olds, regardless of parental income or background characteristics (Quinn, 2017). The United States approach to ECE is a complex array of preschool programs that includes Head Start, state prekindergarten, private and public child care, and preschool special education (Gilliam, 2010). Efforts toward coordination of funds and programs have been sporadic and poorly supported (Gilliam, 2010). In recent years, the U.S. Congress has increased funding for early childhood education. In 2018, Congress provided an increase of \$2.4 billion for the Child Care and Development Block Grant (CCDBG), the main source of federal funding for child care subsidies for low-income working families, and included another \$50 million in fiscal year 2019, which makes the CCDBG total budget \$5.2 billion (Robert Wood Johnson Foundation, 2018). The complex array of programs is difficult for families to navigate and wastes resources and opportunities to develop uniform standards that can improve the reach of the programs in terms of children served and the quality of the programs. Focusing on access and quality is critical, because, as Barnett and Gomez (2016) found, there is wide variation in preschool programs, even those programs that offer universal access. The authors state, “Schedules, standards, funding, and teaching practices vary widely across the ‘universal’ programs . . . Some require as little as 10 hours per week. Others offer a full school day with before- and after-school care, potentially reaching 10 hours per day. Some leave virtually all policy choices and guidance up to the local school district or program. Florida requires little more than a high school diploma of teachers in school-year programs. Others, like New Jersey, set high standards that every classroom must meet, and provide extensive support and guidance. State funding ranges from \$2,200 per child to \$15,000 per child. Observations of teaching practices in statewide evaluations indicate that some programs are overwhelming good to excellent, while others are mostly poor to mediocre”.⁶ Research shows children benefit the most from programs that implement high-quality standards, including having a lead teacher with a bachelor’s degree and specialized training in prekindergarten; an assistant teacher with an associate’s degree in child development; a class size of 20 or fewer students; and a curriculum that is comprehensive, aligned, supported, and culturally sensitive (Friedman-Krauss et al., 2019).

⁶ <http://nieer.org/2016/01/06/universal-pre-k-what-does-it-mean-and-who-provides-it>

In addition to improving access and quality, a nationwide universal ECE system in the United States could diminish stigma and attitudes families and communities may have regarding who deserves access to ECE programs. For example, a poll conducted in the United States suggests there is broad bipartisan support for universal ECE; 76% of those individuals surveyed said such a policy would provide children a better chance to succeed (Brownstein, 2016). Another study found Republicans and conservatives favor universal ECE (Greenberg, 2018). Offering high-quality preschool to all 4-year-old children in the United States has the potential to change norms and attitudes in which Americans see themselves as taxpayers funding services for other families to a more inclusive and collective view of ECE as a public good for all children.

Australia developed a universal ECE system that has a national regulatory framework and curriculum because of the country's concerns regarding future workforce productivity and educational and economic participation. Experts believe one of the reasons Australia was able to deeply embed well-being in the regulatory framework for ECE and The Nest action agenda is because policymakers, practitioners, researchers, and other leaders were already having conversations around the country about what constitutes child well-being and which settings are appropriate to promote it (P. Dakin, personal communication, August 5, 2019⁷). There was political will and social interest in young children's development and a focus on equity and inclusion of more vulnerable children. The ECE system in Australia reflects values such as children's rights, equity and inclusion, and whole-child development that connects mind, body, and spirit. In the United States, there has been some progress in some states and cities, such as New York City, Oklahoma, Vermont, and Washington D.C. that have implemented universal prekindergarten. However, work remains to be done to expand access to high-quality ECE. Local movements in the United States to increase access to ECE may be an effective way to motivate state and federal leaders (Muenchow & Weinberg, 2016). Preschool initiatives in Boston, Denver, Los Angeles, New York City, Salt Lake City, San Antonio, San Francisco, Seattle, Washington D.C., and West Sacramento have shown how community organizers, city leaders, school districts, and others can join forces to find or raise funds to ensure 4-year-olds and, in some cases, 3-year-olds have access a high-quality ECE. As states and local communities work to expand access to high-quality ECE in the U.S., RWJF and other advocates can use the learnings shared in this report on Australia's approach to push for prioritizing well-being in frameworks and standards used by ECE programs. Children's well-being should be the organizing principle in our early learning system.

⁷ Personal communication with Penny Dakin, Australian Research Alliance for Children & Youth, 5 August 2019.

Childhood Obesity in Brazil

In this chapter we explore how Brazil addresses children's well-being through its approach to eating habits. We begin by describing Brazil's population in terms of demographic and health characteristics. Then, we discuss the approach to eating habits emphasized in Brazil's dietary guidelines. We explore the values and norms underpinning the dietary guidelines. We end this chapter by contrasting the Brazilian dietary guidelines with those of the United States and discuss the implications of Brazil's approach to eating habits for well-being initiatives in the United States. The objective of this chapter is not to present an extensive history of malnourishment or food systems in Brazil or the United States nor to conduct an in-depth analysis of both countries' health promotion policies. Our aim is to gain insight from Brazil's approach to children's well-being via its dietary guidelines. RWJF, American policymakers, and advocates can learn from this example on changing social norms by developing dietary guidelines that situate eating in cultural and social contexts and view food and eating as connected to social, familial, and cultural traditions.

Demographics and Health Characteristics

Brazil is an upper-middle-income country that is large in terms of land/geographic size and population, with more than 205 million inhabitants. The national language is Portuguese and, in 2015, 31% of the population was between the ages of 0 and 19. Brazil is one of the most diverse countries in the world; in 2010, 48% of the population was of European descent, 43% multiracial, 8% African, 1% Asian, and less than 1% Indigenous. Similar to the United States, overweight or obesity rates among children in Brazil are high and are a result of several factors, including limited access to affordable, nutritious foods; availability of processed foods that have high amounts of sugar, animal proteins, and fat; sedentary lifestyles; and a decline in physical activity (Monteiro, Conde, & Popkin, 2007). The prevalence of overweight and obesity in Brazilian children aged 10 to 15 nearly doubled, from 17% in 1986 to 32% in 2016 (Brandão, 2017) and, in 2015, one in two adults and one in three Brazilian children are overweight (Ministry of Health of Brazil, 2015). The dramatic increase in children who are overweight or obese in Brazil has occurred in recent decades. Before the 1990s, many Brazilian children were undernourished because of hunger and food scarcity.

Well-Being Issue: Malnourishment From Hunger and Obesity

The government's response to the obesity epidemic in Brazil began in the 1990s. Prior to that, and for many decades, the Brazilian Ministry of Health and public health experts and officials were mainly focused on reducing undernourishment from hunger and food scarcity. In 2014, Brazil was removed by the United Nations from the World Food Program Hunger Map,⁸ which was a critical

⁸ The United Nation's World Food Program Hunger Map tracks the number of people in the world who do not get enough food to lead a normal, active life (World Food Programme, 2018).

accomplishment, resulting from the success of Brazil's social and health promotion efforts. Hunger in Brazil decreased from 22.8 million people in 1992 to 13.6 million people in 2012 (World Food Programme, 2014). The Social Development Minister in 2014, Tereza Campello, said Brazil reduced the number of undernourished people through a “. . . mix of public policies that have ensured more income for the poorest Brazilians, an increased food supply and a consolidation of Brazil's social safety net” (Wilson Center, 2014, webcast). These policies included national government and nongovernmental organization investments in family farming; minimum wage increases; and the conditional cash transfer program, Bolsa Familia, a federal program that provides cash stipends to low income families who keep their children in school, pregnant women who visit clinics for

Brazil's Dietary Guide Golden Rule

“Like all golden rules, the overall rule here is easy to remember and follow: always prefer natural or minimally processed foods and freshly made dishes and meals to ultra-processed foods. In other words, opt for water, milk, and fruits instead of soft drinks, dairy drinks, and biscuits, do not replace freshly prepared dishes (broth, soups, salads, sauces, rice and beans, pasta, steamed vegetables, pies) with products that do not require culinary preparation (packaged soups, instant noodles, pre-prepared frozen dishes, sandwiches, cold cuts and sausages, industrialized sauces, ready-mixes for cakes), and stick to homemade desserts, avoiding industrialized ones”
(Ministry of Health of Brazil, 2015, p. 47).

prenatal and antenatal care, and parents who ensure their children are fully immunized by age 5 and receive growth check-ups until age 6. Luiz Inacio Lula da Silva, Brazil's president from 2003 to 2010, reformed conditional cash transfer programs, including Bolsa Alimentação that was the previous health sector program, by combing them into one program, Bolsa Familia, under the auspices of a new Ministry of Social Development (Lindert, Linder, Hobbs, & de la Brière, 2007). The Bolsa Familia objectives are aligned with the United Nation's Millennium Development Goals (MDGs), for example, reducing malnutrition (MDG 1), achieving universal education (MDG 2), reducing child mortality (MDG 4), and improving maternal health (MDG 5) (Lindert et al., 2007). President Lula da Silva also introduced Fome Zero (Zero Hunger), a program that provided low income families with \$20 a month for food (Ministry of Agrarian Development, 2011). The Zero Hunger program valued human rights—it asserted that all Brazilians have the right to quality food and committed the national government to

create the conditions for the Brazilian population to enjoy this right (Ministry of Agrarian Development, 2011). Studies suggest these national programs reduced hunger and extreme poverty; 36 million Brazilians were no longer living in extreme poverty (Philips, 2016). It is estimated the extreme poverty rate in Brazil was cut in half (from 9.7% in 2003 to 4.3% in 2013) and led to a decline in income inequality (Wetzel, 2013). As Brazilian families moved out of extreme poverty, unintended consequences began to develop. The main diseases that currently affect Brazilians are no longer acute but chronic. Hunger and malnutrition decreased in many children; however,

micronutrient deficiencies and chronic malnutrition are still prevalent in vulnerable groups, including Indigenous people, Maroons, and children and women living in vulnerable areas (Ministry of Health of Brazil, 2015). In the past decade, there has also been a significant increase of adults and children who are overweight and obese, and chronic diseases are the leading cause of death among adults (Pozza, Nucci, & Enes, 2018; World Health Organization [WHO], 2018b)

Governmental Response to the Obesity Crisis: Dietary Guidelines

The Ministry of Health published, in 2006, the *Dietary Guidelines for the Brazilian Population—Promoting Healthy Eating*. These guidelines were the first official national dietary guidelines the Ministry of Health developed for individuals, families, communities, health professionals, and government in promoting healthy eating. In 2011, the Ministry of Health began the process of developing a new edition of the *Dietary Guidelines for the Brazilian Population*, which are a part of the national government’s strategy and policy for food and nutrition and aim to promote healthy eating.⁹ As framed by the Ministry of Health, “. . . a healthy diet is a basic human right. This right implies ensuring permanent and regular access, in a socially fair manner, to food and ways of eating that satisfy the social and biological requirements of everybody. It also takes into account special dietary needs, and the needs to be culturally appropriate, and allow for differences in gender, race, and ethnicity. Adequate and healthy diet should be accessible both physically and financially, and harmonious in quantity and quality, meeting the needs of variety, balance, moderation, and pleasure. Furthermore, it should derive from sustainable practices of production and distribution” (Ministry of Health of Brazil, 2015, p. 8). The Ministry of Health’s view of a healthy diet as a basic human right reinforces the Brazilian constitution of 1988 that recognizes health as a right of citizens and an obligation of the state (Jaime, da Silva, Gentil, Claro, & Monteiro, 2013).

The Brazilian dietary guidelines stress that all people have the right to health and healthy foods and consider the complexity and challenges involved in eating habits and food systems. Unlike the United States’ food guidelines that inform the public about how much proteins, grains, fruits, and vegetables we should eat, the Brazilian guidelines do not focus on nutrients and calories. Instead, the Brazilian guidelines emphasize the social domain of well-being because eating is viewed as a social and cultural activity. The guidelines were informed by the following five principles:

1. Diet is more than intake of nutrients.
2. Dietary recommendations need to be tuned to their times (in other words, reflective of modern food preferences and practices).
3. Healthy diets derive from socially and environmentally sustainable food systems.
4. Different sources of knowledge inform sound dietary advice.

⁹ The National Food and Nutrition Policy and the National Health Promotion Policy in the Sistema Único de Saúde (SUS), the Brazilian national health system.

**Ten Steps in Brazil's
2014 Dietary Guidelines**

1. Make natural or minimally processed foods the basis of your diet.
2. Use oils, fats, salt, and sugar in small amounts when seasoning and cooking.
3. Limit consumption of processed foods.
4. Avoid consumption of ultra-processed foods.
5. Eat regularly and carefully in appropriate environments and, whenever possible, in company.
6. Shop in places that offer a variety of natural or minimally processed foods.
7. Develop, exercise, and share cooking skills.
8. Plan your time to make food and eating important in your life.
9. Out of home, prefer places that serve freshly made meals.
10. Be wary of food advertising and marketing.

5. Dietary guidelines broaden autonomy in food choices.

The Brazilian guidelines focus on meals and encourage families to cook whole foods at home and to be critical of food industry advertising and marketing (Ministry of Health of Brazil, 2015). The Ministry of Health, public health experts, academics, and others who contributed to the guidelines were informed by research showing that, in recent years, Brazilian families often turn to fast food and other ultra-processed foods¹⁰ because they do not have time to prepare meals at home (Alisson, 2018; Philips, 2016). In many families, both parents work and are pressed for time to shop for healthy food and prepare meals (Pinto et al., 2018).

The guidelines acknowledge that time and convenience play critical roles in families' food choices, so they offer simple rules that do not require counting calories or nutrients. The guidelines emphasize utilization of local whole foods and avoidance of processed foods. The guidelines offer 10 specific and straightforward steps to successful eating habits (see sidebar and Exhibit 1). The Ministry of Health and others who contributed to the guidelines reasoned that simple rules are easier for people to understand than gram measurements of proteins and

fats. The rules are also informed by cultural and social practices, such as eating together as a family, and value foods that are an essential part of Brazilian traditions and food supply. The guidelines recommend traditional foods and local ingredients. For example, breakfast can include coffee with milk, cassava cake, cheese, and papaya. For lunch, the guidelines recommend generous portions of rice, beans, and sautéed vegetables. Dinner is more rice and beans plus chicken and acai for dessert.

¹⁰ Ultra-processed food products are industrial formulations made of substances extracted or synthesized from real foods, such as textured vegetable protein, and blended with chemical additives designed to enhance their attractiveness, smell, and flavor. Ultra-processed food products account for 20% of the average Brazilian's total calorie intake (Alisson, 2018).

Exhibit 1. Sample of Recommended Breakfasts in the Brazilian Food Guidelines (2014)



The guidelines were developed for all Brazilians of all ages (2 and older), social classes, and regions. During development of the guidelines, the Ministry of Health posted the guidelines on an online public forum for Brazilians to provide feedback that was incorporated into the final version of the guidelines (Davies, Moubarac, Medeiros, & Jaime, 2018; Food and Agricultural Organization of the United Nations, n.d.). A total of 60,000 copies of the guidelines have been distributed free of charge to health professionals, health centers, schools, and hospitals (Davies et al., 2018).

Response to Brazil's Dietary Guidelines

The dietary guidelines were developed during the rule of the leftist Workers' Party and the presidencies of Lula da Silva and Dilma Rousseff. The guidelines were not accompanied with regulations or restrictions on food labeling or advertising, which has grown in recent years. These regulations are needed as multinational food companies expand in Brazil. In an attempt to reach "emerging-market customers," for example, in 2010, Nestle began sending branded

barges containing chocolate, yogurts, ice cream, and juices down two rivers in Brazil's Amazon region (Mulier & Dantas, 2010). Nestle also has thousands of door-to-door vendors in rural areas that reach a quarter of a million households in Brazil that buy candies, yogurts, infant cereals, and other processed foods (Jacobs & Richtel, 2017). Companies like Nestle are becoming more influential in Brazil in limiting governmental actions. In 2010, Brazilian food and beverage companies joined forces to thwart measures that sought to limit junk food ads aimed at children. Brazil's current president, Jair Bolsonaro, is described as an advocate of far-right policies and as business friendly whose conservative allies in the Brazilian Congress are now seeking to chip away at the regulations and laws intended to encourage healthy eating (Jacobs & Richtel, 2017). For example, shortly after being sworn into office, Bolsonaro disbanded the National Council of Food and Nutrition Security, an advisory board that supported family farms and promoted healthy and sustainable food systems (Michail, 2019).

The public's response to the dietary guidelines has been mixed. Anecdotal evidence suggests that, as Brazilian families' economic status increased, so did their consumption of chips, cookies, and fast food because parents wanted to buy their children the foods they did not have as children (Khazen, 2016; Phillips, 2016). The ability to buy branded snacks also seems to result in fewer children eating the healthy meals provided for free in schools because school food is associated with poverty and branded snacks with wealth (Khazen, 2016). However, recent research findings suggest the relationship between economic status and eating habits is more complicated and not linear. For example, a recent study by Carlos Monteiro (a doctor based at University of Sao Paulo, whose Center for Epidemiological Studies in Health and Nutrition helped conceive the guidelines) shows beneficiaries of the Bolsa Familia program were more likely to buy fresh and minimally processed foods than were nonbeneficiaries (Martins & Monteiro, 2016). Where families live, though, limits access to supermarkets selling fresh produce.

Implications for the United States

Compared to other OECD countries, the United States has the highest rate of childhood obesity, with 31% of children aged 15 overweight or obese compared to the OECD average of 15.5% (OECD, 2017b). Since the 1970s, the percentage of children and adolescents affected by obesity has more than tripled, and, in 2016, nearly 1 in 5 school age children and young people (6 to 19 years old) in the United States had obesity (Centers for Disease Control and Prevention, 2019a). The Centers for Disease Control and Prevention, a federal agency that conducts and supports health promotion in the United States, recognizes that the obesity epidemic is a complex problem that requires policymakers, state and local organizations, business and community leaders, school, child care and health-care professionals, and individuals to work together to create an environment that supports a healthy lifestyle (Centers for Disease Control and Prevention, 2019b). The *State of Obesity*, an annual report from a collaborative project of the

Trust for America's Health and RWJF, has raised awareness about the seriousness of the obesity epidemic in the United States, encouraged the creation of a national obesity prevention strategy, and highlighted promising approaches for reversing the epidemic at the state and local levels. This collaborative project also prioritizes a set of national and state policies to help leaders work to address the nation's obesity epidemic, which include the following:

- Nutrition assistance policies such as Supplemental Nutrition Assistance Program, Women, Infants and Children Program, Child and Adult Care Food Program, and the Healthy Food Financing Initiative (The State of Obesity, n.d.)
- Consumer information policies such as menu labeling, dietary guidelines, and nutrition facts on food labels
- School and early childhood policies such as Head Start, school meals and snacks, school-based physical education, and safe routes to school
- Health coverage and prevention policies such as Medicare, Medicaid, and CHIP; diabetes prevention program; and the Prevention and Public Health Fund

The current U.S. Dietary Guidelines, covering 2015–20, emphasize combining nutrient-dense foods in the same meal and limiting saturated fats, added sugars, and sodium (U.S. Department of Health and Human Services & U.S. Department of Agriculture, 2015). Many experts believe the U.S. dietary guidelines reduce food to its nutrient parts and emphasize weight loss and the relationship between food and obesity (Belluz, 2016). The guidelines do not include recommendations for Americans to reduce their consumption of red and processed meats and sugar-sweetened beverages, such as soda, to prevent chronic diseases despite the strong scientific evidence for those recommendations (Scudellari, 2016). In addition, some experts have argued that the U.S. guidelines are unsupported by the most recent science and do not reflect the health needs of the average American (Volek & Phinney, 2015). Volek and Phinney (2015) assert that dietary guidelines should be simple, realistic, and take into account diverse dietary needs. For example, the 25 percent of Americans who are currently healthy consuming a low-fat diet and the carbohydrate-limiting needs of Americans who are at risk for insulin resistance, metabolic syndrome, and type-2 diabetes (Volek & Phinney, 2015).

In comparison to the U.S. guidelines, the Brazilian dietary guidelines focus on environmental sustainability, as well the connection between eating and social and cultural dimensions. Another critical difference is a focus on human rights—Brazil asserts that a healthy diet is a basic human right and all people should have access to food “. . . *and ways of eating that satisfy the social and biological requirements of everybody*” (Ministry of Health of Brazil, 2015, p. 8). A lesson that can be applied in the United States from the Brazilian approach to the prevention of childhood obesity is to shift dietary guidelines and mind-sets from emphasizing nutrients to

meals and cooking and consider the roles of traditional foods and preparation. The Brazilian dietary guidelines incorporate a “we” mind-set in that food is viewed within the context of family, community, and culture. Policymakers and advocates in the United States tasked with developing the 2020 dietary guidelines should consider the Brazilian guidelines, which encourage families to be critical of the food industry and ultra-processed foods and frame healthy eating as behaviors, norms, and values that involve learning how to cook from scratch and taking the time to sit down and eat with family and friends.

Youth Tobacco Misuse in Canada

In this chapter we explore how Canada addresses children's well-being through its approach to tobacco use by youth. We begin by describing Canada's population in terms of demographic and health characteristics. Then, we discuss the approach emphasized in Canadian policies. We explore the values and norms underpinning the youth tobacco use policies. We end this chapter by examining the response to Canada's youth tobacco use policies and the implications of Canada's approach to well-being initiatives in the United States. The objective of this chapter is not to present an extensive history of tobacco use in Canada or the United States nor to conduct an in-depth analysis of both countries' tobacco use policies. Our aim is to gain insight from Canada's approach to children's well-being via its tobacco policies. RWJF, American policymakers, and advocates can learn from this example on changing social norms by advancing policies that are comprehensive and include regulations and youth substance abuse prevention activities.

Demographics and Health Characteristics

Canada is a high-income country with 10 provinces and three territories. There are two official languages: French and English. Canada's population of more than 35 million is diverse, with origins including Scottish, French, First Nations, Chinese, Ukrainian, and more. Sixteen percent of the 35 million inhabitants of Canada are between the ages of 0 and 14. According to Health Canada, tobacco use is the leading preventable cause of premature death in Canada (Health Canada, 2018a; Health Canada, 2018b). More than 45,000 Canadians die annually from illnesses caused by smoking, which translates to about one Canadian every 12 minutes (Dobrescu, Bhandari, Sutherland, & Dinh, 2017).¹¹ In a single year, smoking costs in Canada are more than \$6.5 billion for direct health care and \$16.2 billion in combined health and economic costs. Tobacco use also indirectly impacts nonusers, such as families and friends caring for the ill and grieving those who have passed away. Other costs, estimated at \$9.5 billion in 2012, included productivity loss when workers missed work because of a smoking-related condition. Dobrescu and colleagues (2017) found workers who became ill while in the workforce lost an average of 7 years of their productive work life and, in 2012, they estimated 599,390 potential years of life were lost because of smoking, which means smoking took an average of 13 years from the lives of people who became ill.

Numerous studies have shown the dangerous effects of nicotine on adolescent well-being, for example, higher risk for addiction and affective disorders in adulthood (Counotte, Smit, Pattij, & Spijker, 2011), epigenetic changes that sensitize the brain to other drugs and increase the risks for future substance use (Yuan, Cross, Loughlin, & Leslie, 2015), and other deleterious and long-

¹¹ In 2012, smoking caused 18% of all deaths in Canada (Dobrescu et al., 2017).

lasting impacts on the brain (Harvey, Chadi, & Canadian Pediatric Society, Adolescent Health Committee, 2016).

Compared to other countries, Canada has one of the lowest percentages of youth smoking (OECD, 2016). However, public health experts believe the increasing popularity of flavored tobacco products and e-cigarettes may be reversing the progress Canada has made in reducing youth tobacco use (Harvey et al., 2016). This is a disturbing trend occurring in the United States as well. In 2018, among Canadians ages 16 to 19,

- 37% reported having ever tried an e-cigarette,
- 15% vaped once in the past 30 days,
- 9% vaped in the past week, and
- 4% reported vaping on a regular basis (more than 15 days in the past 30 days) (Hammond et al., 2019).

In addition, use of e-cigarettes increased significantly between 2015 and 2017, and e-cigarette use was most prevalent among Canadians under the age of 34 (University of Waterloo, 2017). E-cigarettes with fruit flavors were most popular among younger users, and use varied by province, with prevalence being the lowest in Ontario and highest in Nova Scotia. Tobacco products with added flavors and branding may be appealing to young people, and the presence of smoking in their families, communities, movies, and videogames may signal to youth that smoking is an acceptable social norm (Tobacco Endgame Cabinet, 2019).¹² Studies show that, although e-cigarettes are generally less harmful than combustible tobacco cigarettes, they carry significant risks, including nicotine exposure and addiction (National Academies of Sciences, Engineering, and Medicine [NASEM], 2018). A report developed by NASEM also expressed concern about flavor additives, concluding that independent of nicotine, exposure to particulates and flavorings in e-cigarette aerosols could also potentially impair lung function (NASEM, 2018).

Governmental Response to Tobacco Use: Canada's Tobacco Strategy

Canada has been a world leader in tobacco control for many years. The Tobacco Act (now the Tobacco Products and Vaping Act) passed in 1997, and its amendment, Bill C-32, passed in 2009, provided the basis for federal tobacco regulations (Reid & Hammond, 2015). Canada has a comprehensive tobacco control environment with responsibilities shared by multiple levels of government. In addition to federal initiatives, all provinces, territories, and municipalities currently have tobacco control legislation in place, some with restrictions beyond those found

¹² Getting to less than 5% by 2035: The 2019 tobacco endgame report <https://www.lung.ca/sites/default/files/EndGameReport-final.pdf>

in the federal Tobacco Act. In 2001, Canada became the first country to implement pictorial health warnings on cigarette packs and, in 2004, was one of the first 40 countries to ratify the WHO Framework Convention on Tobacco Control—the world’s first global health treaty aimed at combating the tobacco epidemic (ITC Project, 2013). Canada also implemented comprehensive product regulations, including a ban on all flavorings (except menthol) in cigarettes, cigarillos, and blunt wraps in 2010, but added a ban on menthol in 2017 (Chung-Hall et al., 2018; Reid & Hammond, 2019). In February 2020, Canada will fully implement plain and standardized packaging regulations to eliminate the use of design features, such as colors, graphic design, and package shapes on tobacco products, which are known to increase the appeal of tobacco products among youth as well as adults. Plain packaging has been shown to be effective in greatly reducing the appeal of cigarettes in a number of countries, including Australia, the United Kingdom, France, and New Zealand (Health Canada, 2019).

The Canadian government launched the Health Canada–led Federal Tobacco Control Strategy in 2001 to achieve tobacco use reductions through a comprehensive, integrated, and sustained approach. In 2018, a new federal strategy was announced to reach an ambitious endgame target of less than 5% tobacco use by 2035—or less than 1.8 million tobacco users—with a commitment of \$330 million during the next 5 years to help Canadians who smoke to quit or reduce the harms of their addiction to nicotine and to protect the health of young people and nonsmokers from the dangers of tobacco use (Health Canada, 2018c). A recent report by the Tobacco Endgame Cabinet (2019) identifies the following strategies to reach less than 5% tobacco use by 2035 in Canada:

- Increase taxes
- Comprehensive cessation strategy
- Reduce the number of tobacco retailers
- Ban all promotional relationships between tobacco manufacturers and retailers
- Implement smoke-free social housing
- Adopt measures to prevent uptake of e-cigarettes by youth and by those who do not smoke by preventing advertising and promotion and by curtailing retail store availability to adult-only specialty vape stores.

The youth strategy includes providing educational activities about the risks of tobacco use, vaping products, and nicotine addiction and enforcing compliance for retailers and producers of tobacco and vaping products. The government also asserted a commitment to address disparities in tobacco use, which are often linked to other health and social inequities. The government is dedicated to reaching out to groups of Canadians with higher rates of tobacco use, including LGBTQ+ individuals, young adults, and Indigenous peoples.

The Canadian strategy also notes that giving smokers access to less harmful options than cigarettes will help reduce their health risks and possibly save lives. Canada recognizes the potential value that vaping products like e-cigarettes have to help adult smokers quit and, at the same time, recognizes the need for strong regulations to combat youth uptake of vaping products.

In 2010, the Canadian Centre on Substance Abuse and Addiction and the Canadian Standards Task Force, a group of Canadian prevention professionals, developed the Portfolio of Canadian Standards for Youth Substance Abuse Prevention as a part of an initiative that aimed to reduce illegal drug use by Canadian youth aged 10 to 24 years (Canadian Centre on Substance Abuse, 2014). This portfolio is a series of guides for professionals participating in youth substance abuse prevention activities in health promotion, education, social and community development, public safety, and enforcement. The objective is to provide prevention teams with a resource containing expert guidance and tools to strengthen the quality of their efforts in order to promote the health and well-being of youth. The activities and guidebooks in the portfolio call for professionals working with youth to approach well-being in a holistic manner that includes physical and social well-being and settings important for youth development, including school, community, and family. The portfolio includes a set of three guidebooks: standards for prevention in communities (*Stronger Together*), standards for prevention in schools (*Building on Our Strengths*), and guidelines for families (*Strengthening Our Skills*) (Canadian Centre on Substance Abuse, 2014).

The Canadian approach to the prevention of youth use of tobacco includes recognition of the role social norms play in adolescence. Young people tend to be influenced by their perceptions of how common or normative substance use is in their networks. If friends smoke, drink, or use other substances, a young person is more likely to do so (Eisenberg, Toumbourou, Catalano, & Hemphill, 2014). The social norms approach aims to correct misconceptions that a group has about a perceived behavior and posits that, by correcting this misconception, the norm can be changed. Interventions can be effective when they correct misconceptions that youth have when they overestimate the percentage of their peers who smoke or drink and the amount that they smoke or drink (Hughes, Julian, Richman, Mason, & Long 2008; Sheikh, Vadera, Ravey, Lovatt, & Kelly, 2017). This information can be used to change perceptions that are more in line with actual behaviors. Research examining the role of social norms in youth substance abuse notes it is important to make distinctions between norms to inform message development. Eisenberg and colleagues (2014) distinguish between the perceptions that students hold about substance use, what the authors called injunctive norms, and students' actual behaviors, or descriptive norms. The researchers found that schoolwide norms concerning substance use were associated with substance use in subsequent grades but that injunctive norms had less of an association. The study concluded that social norms approaches could be effective for

prevention but that measures to address descriptive norms will be most successful (Eisenberg et al., 2014).

Response to the 2018 Tobacco Strategy

The tobacco industry typically claims that policies needed to curb tobacco use will result in a public backlash because they interfere with smokers' rights (University of Waterloo, 2018). However, findings from a recent poll of smokers in Canada do not support this claim. Chung-Hall and colleagues (2018) surveyed 3,215 adult smokers and found, across a set of proposed policies to reduce tobacco use, support was highest for reducing nicotine content (70%), raising the legal age for purchase (70%), increasing access to alternative nicotine products (66%), and banning marketing (59%). The majority of smokers surveyed supported restricting youth access (86%), restricting nicotine content (65%), prohibiting use in smoke-free places (63%), and banning marketing (55%).

Implications for the United States

Evidence collected by the Centers for Disease Control and other organizations shows the trends in tobacco misuse in Canada are similar to those in the United States (Centers for Disease Control and Prevention, 2019c; Cullen et al., 2018; NAESM, 2018). There was progress in the U.S. in past decades at reducing the use of tobacco by young people. However, once e-cigarettes entered the U.S. marketplace in 2007, the popularity of e-cigarettes began to reverse progress and has resulted in a dramatic rise in youth uptake of tobacco (Cullen et al., 2018; U.S. Food and Drug Administration, 2019). For example, there was a 78% rise in youth e-cigarette use from 2017 to 2018 (Centers for Disease Control and Prevention, 2019c). Cullen and colleagues (2018) attribute the popularity of e-cigarettes among youth to the designs and flavors of e-cigarettes. For example, JUUL and other manufactures sell USB-flash-drive-like e-cigarettes that have high nicotine content, appealing flavors, and the ability to be easily concealed and used discreetly.

The American Lung Association and other advocates recommend the United States federal government and state governments raise the minimum age to buy tobacco products to 21, impose higher tobacco taxes, and encourage more aggressive U.S. Food and Drug Administration (FDA) regulation of the manufacturing, marketing, and sale of tobacco products to combat the rise of youth smoking e-cigarettes (American Lung Association, 2019). RWJF has also called on the federal government to do more to combat youth tobacco use. For more than 25 years, RWJF has worked with national and local health organizations, faith groups, businesses, government, and others to advocate for higher tobacco taxes, strong smoke-free air laws, and well-funded programs to prevent youth from smoking and help smokers quit.¹³

¹³ For more information about the foundation's efforts in tobacco control, please see <https://www.rwjf.org/content/rwjf/en/library/collections/tobacco-control.html>.

Presently, the foundation is continuing these efforts by working to reach communities nationwide that have not benefited equally from reduced smoking rates. Richard Besser, MD, RWJF President and Chief Executive Officer, submitted the following comments to the FDA on its advanced notice of proposed rulemaking (ANPRM) on regulation of flavors in tobacco products: *“By issuing this ANPRM, the U.S. Food and Drug Administration (FDA) has taken an important step toward developing a rule that has the potential to reduce tobacco-related disparities and youth uptake of tobacco products. We urge FDA to develop a proposed rule that prohibits the use of characterizing flavors in all combusted and smokeless tobacco products, including the use of menthol as a characterizing flavor in cigarettes, as quickly as possible. The proposed rule should prohibit characterizing flavors in e-cigarettes unless the manufacturer demonstrates, for a specific flavor in a specific product, that the presence of the flavor helps smokers quit tobacco products entirely or at least switch completely to an e-cigarette and that the benefits of the flavoring in helping smokers quit or switch outweigh the potential for youth initiation”* (Besser, 2018, p. 1). In March 2019, the FDA released *Modifications to Compliance Policy for Certain Deemed Tobacco Products: Guidance for Industry*, which is a draft document about the agency’s thinking on changes to compliance policies for premarket review requirements for e-cigarettes. The draft document also describes how the FDA intends to prioritize enforcement resources with regard to the marketing of flavored electronic nicotine delivery systems (ENDS) products (other than tobacco-flavored, mint-flavored, and menthol-flavored ENDS products) that are offered for sale in ways that pose a greater risk for youth to access such products. On August 16, 2019 (Department of Health and Human Services, FDA, 2019), the FDA released a proposed rule on graphic warnings on cigarette packages. These graphic components would depict the negative health consequences of smoking and would include new textual warnings. The FDA is motivated by findings in the scientific literature that show American youth and adults, smokers and nonsmokers, have misperceptions about the health risks caused by smoking (Department of Health and Human Services, FDA, 2019). These warnings on packages would demonstrate to users and/or potential users the dangers of smoking cigarettes.

Although the FDA is committed to reducing youth tobacco use and has a comprehensive plan on nicotine and tobacco regulation (U.S. Food and Drug Administration, 2017), more can be done to prevent youth initiation and use of tobacco. RWJF, the American Lung Association, and other advocates in the United States could learn from the comprehensive strategies, regulations, and resources the Canadian government enacted to prevent youth tobacco use and the damaging impacts on youth well-being. We found Canada’s governmental response to youth tobacco use places a high value on evidence to surveil trends and to inform intervention design, including findings from international research. A related and perhaps distinct point is that value is placed on cost in terms of current and future expenditures because prolonged substance use will affect

all domains of well-being. Efforts in the United States should include a public awareness campaign, interventions focused on changing norms, and school-based strategies working in conjunction with communitywide strategies that reach young people in other non-school settings, such as families, recreational environments, postsecondary institutions, and workplaces. In addition, it is essential that American policymakers look to and support studies in countries where proposed policies have been already implemented to learn whether the policies are effective and the conditions that support their implementation.

Public Education in Finland

We review public education in Finland, which is world renowned for its educational outcomes. The point of this chapter, however, is to investigate the process of implementing education. This example demonstrates how to operationalize well-being and how a focus on the values that support the process of education can lead to positive outcomes.

Finland ranks at or near the top of global well-being indices. Finland ranks first in 156 countries reporting on the 2019 World Happiness Report's Ranking of Happiness 2016–2018 (Helliwell, Layard, & Sachs, 2019). In the Global Youth Development Index and Report by the Commonwealth Secretariat (2016), Finland ranks 25 out of 183 countries. Finland is 9 out of the 40 countries in OECD's Better Life Index (2019).

Education in Finland provides a useful lens to look at child well-being. Finland has consistently been a top international performer in the Program for International Student Assessment (PISA), a survey administered every 3 years since 2000 for 15-year-old students, including the OECD countries and others that assess learning outcomes in reading, mathematical, and scientific literacy. This high-profile assessment has brought international fame to the Finnish education sector, including press coverage and research tours (Schatz, Popovic, & Dervin, 2017). The focus of this chapter is how these outcomes are interpreted and used by educators and administrators to focus on what matters most to them—the well-being of their learners.

The Well-Being Issue

Although Finland ranks high on PISA, recent administrations in 2013 and 2015 showed a slight decline in the country's relative ranking. In 2015, the PISA results indicated an 11-point drop in science scores, a 5-point drop in reading, and a 10-point drop in mathematics. Finland descended from 3rd to 5th in science, from 2nd to 5th in reading, and from 6th to 12th in mathematics. The decline in PISA rankings, although a small dip, grabbed headlines:

- Finland Used to Have the Best Education System in the World—What Happened? (Taylor, 2013)
- Finland's Schools Were Once the Envy of the World. Now, They're Slipping. (*Washington Post*, December 8, 2016)
- Helsinki: Europe's Top Performing School System Rethinks Its Approach (*The Economist*, May 12, 2016)



The government's reaction to these results and the negative press attention provide insights into how education and child well-being are viewed in the country. The reaction was muted and precise. A 2016 Ministry of Education and Culture press release stated: "The PISA 2015 scores send an ambivalent message. On one hand, Finland is still a top-ranking country in education. The decrease in learning outcomes, observed already for the past ten years, has leveled off in reading literacy and slowed down in mathematical literacy. The differences between the Finnish schools are still minimal. On the other hand, the scores raise concern for equality in education, especially for the situation with boys. The influence of the socioeconomic background on the learning outcomes has grown. We must consider which of the changes occurring in our schools or society have led to the situation where so many boys are not interested in the learning model applied. The scores indicate that the comprehensive school is in urgent need of reforms."

A leading education observer noted that the results were not a surprise to education administrators because processes were already in place to gather these data but that there would be a national campaign to study the results. He observed, "No one has responded to the data by saying Finland needs to focus just on math and reading, or on any other silver bullet. Instead, the discussion is about how Finland can improve the system as a whole and increase enjoyment in learning. It is not just about how to improve our performance on PISA." (Tucker, 2014).

The Response

The Ministry of Education and Culture organized a Comprehensive School Forum in 2016 with the aim of improving the public education system holistically. The researchers and experts at the forum drew up "policies and guidelines to merge the national perspective, combining the goals of education providers, teachers, students, and the community of growth. The policies and guidelines help carry out the national core curriculum, promote learning, and enhance well-being." A wide range of stakeholders took part in the forum, including educators, administrators, parents, students, academics, government, organized labor, and the private sector. The result was a new comprehensive education initiative described in *Finnish Basic Education—Excellence Through Equity for All*, a sector-wide commitment." Key features of the commitment include the following:

- Clear value basis as a starting point for developing the basic education system

- Collaborative school culture in which all students and teachers can participate in common interests and activities
- Well-being in school, including a safe and supportive learning environment free from bullying and discrimination, and accommodating schedule for learners and teachers
- Support for teachers in a changing environment
- Personalized learning paths so that all students can participate and reach their full potential
- Strong basic skills pave the way to future competencies and include literacy, numeracy, and critical thinking
- Active parental and community involvement
- Research-based development, using and building an evidence base to inform action
- Evaluation and assessment supporting equity, including measures to ensure that all students can demonstrate their skills and knowledge in different ways

The policies and guidelines drawn up by the forum applied to all Finnish schools and students of all ages. With the aim of raising student motivation to study and overall well-being in school, the comprehensive reform targeted whole-child development with the goal of offering equal educational opportunities for everyone. In addition to the Comprehensive School Forum, the Ministry of Education and Culture released the New Comprehensive School Action Plan, a 3-year 90 million-dollar plan launched in 2016. The plan details actions to take in support of learner-centered education, competent teachers, and collaborative school cultures.

In conjunction with a new core curriculum, the New Comprehensive School Action Plan stated that every comprehensive school would be “granted a tutor to guide other teachers, the support the realization of new pedagogy, and to promote and advance the digitalization of teaching.” Additional aspects of the reform included The Schools on the Move program, a program designed to encourage every child and young person to engage in physical activity for at least 1 hour a day to increase school satisfaction, and LUMA Finland, a program launched to support competence of children and youth in mathematics and natural sciences through inquiry-based learning.

Regarding implementation, the guidelines and policies are provided at the national level, although a lot of autonomy is given to school leadership who are expected to work with teachers and the school community to set goals and objectives. According to the New Comprehensive School Action Plan, “The open atmosphere in the new comprehensive schools cultivates a sense of community. Schools evolve into more interactive environments from the bottom up and the operating culture makes it possible to disseminate and adopt best practices and effective models everywhere” (Ministry of Education and Culture, 2016b).

It should be noted that these programs are in addition to a wide base of social services. Primary and secondary education is free—inclusive of materials and meals; health and dental care are provided; guidance and counseling and psychological supports are offered; services for special needs learners are also provided; and other services, such as commuting support and remedial education, are available (Ministry of Education and Culture, 2016a). According to one researcher, education in Finland is built on the foundation of the Nordic Welfare state that feature “citizens’ equal social rights; responsibility of public authority (the state) for the welfare of all citizens; striving towards the narrowing of differences in income and of gender inequality; and, striving towards full employment” (Antikainen, 2006).

Education in Finland has been affected by many changes in the past several decades. These changes include the transition from an agrarian to industrial society, economic depression and stagnation, a neoliberal turn after the fall of the Soviet Union, a robust economic growth bolstered by the success of Nokia, to the present day (Antikainen & Pitkänen, 2014). The Nordic foundation, described by one author as striving for a “fairer, happier, more secure, and less stressful society for themselves and their children,” may provide the stability for administrators to cope with these changes effectively, including a light drop in PISA scores (Partanen, 2016).

Implications for Well-Being Initiatives in the United States

The example of the Finnish government’s response to PISA scores gives insights into how educators, administrators, and parents view the welfare of their children. The undergirding message of the commitment is that the nation has a collective responsibility to support the right of every individual to achieve a high-quality education. The ministry applies a well-being lens to administer education. Test scores are just one measure; but more goes into the learning experience of a child that contributes to the child’s development. The ministry emphasizes equity of opportunity and equality of experience, as evidenced in policies and social support programs. Inclusivity is an explicit value, as evidenced in the participatory process to design the commitment, the emphasis on collaboration in daily practice, and the focus on supportive and nondiscriminatory learning environments. The commitment also shows that the leaders in education value forward thinking and embrace change because they created measures that allow school communities to evolve to meet the needs of learners as they grow and develop and to respond to a changing society.

In the policy documents and the literature that we reviewed we found more of an emphasis on the process and conditions for achieving the objectives, rather than specific numeric targets. The stakeholders in the system are galvanized by a common understanding of the purpose and methods of education, but implementation is carried out in a decentralized way at the school level. This suggests that the values, support inputs, and good practices associated with high-quality education are the priority, and, although specific measures are useful to guide planning

and implementation, they are not a goal in and of themselves. The process matters, and that process is collaborative and flexible but bound by a shared vision.

The Finnish example shows how U.S. planners can apply a well-being lens to education, where scores are not the sole focus of the system; but the process, inputs, and practices that support well-being are the focus. This example also demonstrates to planners that child well-being is a dynamic concept that calls for collective action to renew the nation's commitment.

However, it may be that these education reforms can be enacted in this way when the key stakeholders share the same premise. That premise is expressed here as the Nordic aims of a fair, happy, secure, and less stressful society. Whether this Nordic concept can be successfully adapted to other contexts is an open question; however, its utility for addressing child well-being is clear and thus warrants further inquiry.

Youth Suicide Prevention in Japan

The issue of youth suicide prevention in Japan is a case that demonstrates how to push an issue, which is surrounded by stigma and privacy, into the public domain by calling for a national response. The challenge was to change the mind-set from considering suicide as an issue confined to the individual and family to an issue of collective social responsibility. The efforts emphasized the ecology of suicide prevention, how different conditions can intersect and ramify, affecting one's well-being.

Japan has the third largest economy, with a population close to 128 million people. Children and youth comprise 18% of the population in Japan. The nation's rankings on well-being indices are lower than many of their peer industrialized countries. Children in Japan are less likely to report a positive sense of life satisfaction than their counterparts in other countries; the average score of life satisfaction for 15-year-old students was 6.8, below the OECD average of 7.3. Japan ranks 58th of the 156 countries reporting on the 2019 World Happiness Report's Ranking of Happiness 2016–2018 (Helliwell et al., 2019). Japan is 25 out of the 40 countries in the OECD's Better Life Index (2019). Although, in the Global Youth Development Index and Report by the Commonwealth Secretariat (2016), Japan ranks 10 out of 183 countries, supported by a strong score in education.

According to the OECD, 82% of 15-year-old students agreed with the statement, "I feel like I belong in school," which is above the OECD average of 73%. In comparison, 12% of the surveyed adolescents reported feeling like outsiders at school. Despite reporting a strong sense of belonging at school, 22% of 15-year-old students indicated being bullied at school. Bullying is a driver of youth suicides among males and females in Japan (Hidaka et al., 2008). This finding suggests that, although social exclusion can be relatively rare, it can also be acute, with severe consequences. Though it should be noted that bullying is not the only driver of youth suicide, academic stress, health concerns, and family problems also contribute to youth suicides (Y. Matsumoto, personal communication, August 3, 2019).¹⁴

The Well-Being Issue

In 2015, WHO reported, "Japan has long battled one of the highest suicide rates in the industrialized world. In 2013, its national rate of suicide stood at 21.4 deaths per 100,000 people— well above that of other high-income countries (12.7 deaths per 100,000 people)." The report also noted that progress had been made since the beginning of the century. According to WHO (2015), suicide was once a taboo subject that brought shame to the families, who often struggled in private because there were few mechanisms for support.

¹⁴ Personal communication with Professor Yuki Matsumoto, Tokushima Bubishi University, August 3, 2019.

Research by Russell et al. (2017) suggests that suicide has been an aspect of culture in Japan for several centuries. Suicide in Japan dates to the feudal periods where samurai performed ritual suicide out of loyalty and honor. This tradition may contribute to modern attitudes that are less critical of suicide than in other high-income countries (Takeshima et al., 2015). Possibly, this tradition also contributed to a spike in suicides associated with the financial crisis of 1998 and its aftermath. At the same time, this increase in suicides may have also been the impetus to change the national discourse on this issue. According to one report, a group of children who had lost parents to suicide organized, gathered media support, and advocated for action by the national government by making an effective plea to the prime minister in 2002 to act on the issue (Takeshima et al., 2015).

Another contributing factor to action was the relative ranking among industrialized countries, to which the government refers in its white papers. In December 2002, the Japanese Ministry of Health, Labor, and Welfare's Special Committee on Prevention of Suicide released a national report on suicide prevention confirming the suicide death rate increasing from 18.8 to 25.4 per 100,000 people from 1997–98 and remaining high in 2001 at 23.3 (Ueda & Matsumoto, 2003). The committee's recommendations included focusing on the detection and treatment of depression and expanding understanding regarding mental health. This initial effort became the foundation for suicide prevention efforts that carry on into the present day.

In 2005, LIFELINK, a nonprofit organization focusing on suicide prevention partnered with a parliamentary member to coordinate the first ever symposium on suicide prevention and urged other nongovernmental organizations to submit proposals for comprehensive suicide prevention. The Minister of Health, Labor, and Welfare attended the symposium and expressed his commitment to the cause (WHO, 2015). The Suicide Prevention Liaison Committee was formed subsequently. The 2006 Basic Act for Suicide Prevention and the 2007 General Principles of Suicide Prevention (GPSP) policy laid the foundation for a successful comprehensive suicide prevention effort, whereby suicide rates have been declining since 2009 (Takeshima et al., 2015). These principles outlined nine national objectives to guide practices and activities related to suicide prevention in support of the Basic Act, which included investigating the conditions of suicide, increasing public awareness, conducting early response training, promoting mental health, coordinating with civil society, and providing series and support.

Preventing suicides among middle-age men were the focus of efforts at the start of the century. Youth suicide came into focus in the second decade because the data showed Japan was an outlier among its peer nations.

The Response to Youth Suicide

Youth suicide is a focus of two policy documents—the Vision for Children and Young People (2010) and the Basic Law on Suicide Countermeasures (2016)—that we review in this section. The vision document states, “In view of the serious situation that Japan is the only country among the Group of Seven nations where suicide is the top cause of death among young people aged 15 to 34, efforts will be made to promote awareness-raising programs during ‘Suicide Prevention Week’ and ‘Suicide Prevention Month,’ and to improve mental health promotion and counseling systems in local communities. In addition, improvements will be made to the gate-keeper functions and outreach (home-visit support) programs, mental healthcare reforms will be promoted, and efforts will be made to improve systems for preventing suicide.” Further, the document lists specific actions, such as early stage detection and school-based counseling (Vision, 2010).

The basic law states, “With the aim of ensuring that all people are valued as human beings and are able to live meaningful lives with hope for the future based upon their zest for living, suicide countermeasures must be implemented as comprehensive support for people’s lives in a way that contributes to overcoming various factors that may interfere with the accomplishment of this aim and widely and appropriately establishing and enhancing the environment to assist and facilitate such support. . . . Suicide countermeasures must be implemented as a society-wide effort based on the fact that suicide should not be merely viewed as a personal problem, but rather involves various social factors behind it.” This statement marked a critical point for social change.

The law further describes an ecological approach to addressing the issue and calls for tailored measures suited for different contexts. The law calls for comprehensive suicide prevention measures coordinated among several sectors, including health, welfare, education, and labor, and by several actors, such as government, businesses, and the general population. The Youth Policy Vision prioritizes bullying and exclusion as well as mental health promotion for suicide prevention. The law also mobilizes the population by stating, “The people in Japan shall endeavor to deepen their awareness and understanding of the importance of suicide countermeasures as a means of comprehensive support for living.” This position is a move toward well-being promotion, rather than strictly suicide prevention.

The Cabinet created a special fund for local government use as a financial incentive for program creation. In accordance with the early response training objective, Japan’s Ministry of Health, Labor, and Welfare published gatekeeper training program resources on its website that included handbooks and video lectures (Yonemoto et al., 2019). The revision of the GPSP policy also reaffirmed March as the national suicide prevention month. To raise awareness, the Cabinet released posters that were to be distributed nationwide. The posters leveraged the recognizable all-girl singing group, AKB48, and called on young people to declare themselves

gatekeepers. During 2012, the Cabinet also published and made publicly available a white paper on suicide prevention in Japan. The white paper outlined the situation on suicide rates, and, more importantly, it highlighted the implementation progress from the GPSP policy.

Although the national government outlined specific priority objectives, it granted local governments autonomy in focusing on practices that would best fit their community needs. Local governments were expected to act in developing community-based programs and initiatives that would best fit their circumstances. However, the interventions have been critiqued for the decentralization of implementation. Specifically, some interventions were not implemented effectively, and more guidance could remedy this shortcoming. An evaluation of the national suicide prevention strategy found that “the national fund promoted the establishment of community systems for suicide prevention and helped implement initiatives among local authorities. The national suicide-prevention strategy in Japan should explore a standard package of programs to guide community suicide-prevention efforts with a sustained workforce among local authorities” (Nakanishi et al., 2015).

The government plans to double the number of social workers available to youth and maintain an online platform and a 24-hour telephone support line. Although these efforts are targeted and demonstrate a government commitment, they do not echo the well-being promotion efforts earlier in the response. Youth are stressed, isolated, and under pressure to conform. Schooling in Japan features high-stakes testing, parents are working long hours and may offer less support to their children than they need and, social media can be depressing and alienating. The current response is not direct to the underlying issues that may contribute to suicides.

The policy documents we reviewed provide principles and guidance. However, more research is needed to understand the needs of youth and how these principles and guidance were translated into action at the school and community levels to understand this recent trend.

Implications for Well-Being Initiatives in the United States

In reviewing these policy statements, we see that the relative ranking among peer countries can inspire action among policymakers. We also see that individual rights are valued, but so too is collective responsibility. The position is clear that suicide is a social concern, not just a problem for individuals and families. The government was able to counter a centuries-old narrative about suicide by challenging taboos and privacy by pushing the issue into the public sphere. The government used extensive public awareness strategies and appealed to the public a sense of social responsibility to effect norms change.

Whereas the Youth Policy Vision includes suicide prevention in the context of an overarching aim to support children in living active and happy lives, the Basic Law on Suicide Countermeasures is focused on the prevention of suicide rather than on the explicit promotion of well-being more broadly. This may be a missed opportunity to transcend the idea that suicide is a singular act, but rather to understand suicide as a manifestation of complex factors that can cause one harm. Therefore, to prevent youth suicides is to promote youth well-being more broadly.

The tactic of a decentralized approach to implementing suicide prevention efforts has a face-value validity; programs can be adjusted to the needs of the local community. However, evidence-supported practices and interventions require fidelity of implementation. Thus, strict guidance is needed for program efficacy. Planners of child well-being programs should be able to balance fidelity with customization.

For program planners in the United States, this example shows that social norms can change from society-wide factors, such as the economic conditions that contributed to an increase in suicides, and that intentional efforts can be taken to respond to these conditions to effect positive change. Starting with surveillance data and international comparisons, the government was able to direct programs and campaigns to mobilize the public by invoking empathy and compassion and a message of well-being and positive living. These efforts have showed positive results. Some version of this approach may be warranted for the youth as well, but further research is needed.

Breastfeeding in South Africa

In this chapter we look at a national effort to increase the number of new mothers who exclusively breastfeed their babies. By investigating this issue in South Africa, we can gain insights into how to change public perceptions and to underscore the importance of changing social norms that support well-being behaviors generally.

South Africa is a middle-income country that has consolidated its democracy after transitioning from decades of apartheid rule. In well-being measures, the country is in the lower half on international rankings. Although it is classified as upper-middle-income, the consequences of apartheid remain. South Africa ranks 106 in 156 countries reporting on the 2019 World Happiness Report's Ranking of Happiness 2016–2018 (Helliwell et al., 2019). In the 2016 Global Youth Development Index and Report by the Commonwealth Secretariat, South Africa ranks 126 out of 183 countries. South Africa is last of the 40 countries in the OECD's Better Life Index (2019). These rankings mask the wide range of inequality in the country along race and location. The Gini coefficient for South Africa in 2015 was 0.62, and, according to World Bank estimates, South Africa is the world's most unequal country. More than two decades after the end of apartheid, most of the nation's wealth remains in the hands of a small elite (Beaubien, 2018). South Africa is also burdened by one of the highest HIV prevalence rates in the world.

Although the pace of progress is slow, South Africa is making progress in achieving the United Nation's Sustainable Development Goals—there have been advances in the health conditions for young children, for example. Exclusive breastfeeding of infants 0 to 6 months of age has dramatically increased, with 32% of infants under 6 months exclusively breastfed, compared to 1998 when only 7% of infants were exclusively breastfed. Thus, child mortality rates are now the lowest in the nation's history (UNICEF, WHO, World Bank, & UN DESA Population Division, 2017).

The Well-Being Issue

The case of South Africa is an example of creating social behavior change. It shows that, even in resource-constrained environments and a heavy communicable disease burden, leaders can take measures to improve child well-being, especially in the first days of life. We investigate a successful national effort to promote breastfeeding for healthy growth and development and a foundation for well-being.

A challenge that public health professionals faced was to send accurate messages to change norms and behaviors in the context of the fear and misinformation that was often associated with HIV prevention. South Africa has one of the highest HIV prevalence rates in the world. In early prevention efforts, public health leaders discouraged breastfeeding to prevent mother-to-child transmission of the virus. In 2002, South Africa implemented the Prevention of Mother-to-

Child Transmission of HIV program in hopes of reducing the number of infant HIV infections. As part of the program, the South African government distributed free formula to mothers for up to the first 6 months of infant feeding. This was in line with the WHO guidelines of the time published in 1998, which stated that “when replacement feeding is acceptable, feasible, affordable, sustainable and safe avoidance of all breastfeeding by HIV infected mothers is recommended.” Some scholars believe that this initial practice not only increased formula feeding for HIV-positive mothers but also among the general population (Ijumba, Doherty, Jackson, Sanders, & Persson, 2013). In 2003, the South African Demographic Survey indicated that only 8% of infants aged 0–6 months were exclusively breastfed, making it the lowest rate in the world (Bloemen, 2012).

With advances in the efficacy of antiretroviral drugs, guidance to mothers has changed. In 2006, WHO, along with other agencies, published the *HIV and Infant Feeding Report*. The research indicated that exclusive breastfeeding for up to 6 months was associated with >50% reduction in the risk of HIV transmission in comparison with nonexclusive breastfeeding. In addition, the research cited that early cessation of breastfeeding was associated with an increased risk of infant morbidity and mortality in HIV-exposed children (WHO, 2006). Based on these findings, WHO revised the guidelines on HIV and infant feeding once more, encouraging decision makers to expand antiretroviral services for mothers to exclusively breastfeed.

The Response

The Department of Health recognized the importance of breastfeeding to child health and development, taking measures to respond to the new international guidance. Infant mortality remained high in the country, spurring further action, which the then health minister deemed “unacceptable” (South African Government News Agency, 2011). In 2011, leaders from the Ministry of Health and Civil society, along with experts from the United Nations Children’s Fund (UNICEF) and WHO, held a consultative meeting that resulted in a declaration to address the issue—the Tshwane Declaration of Support for Breastfeeding in South Africa. The declaration and subsequent policy made clear the position of the government and provided a clear rationale for action.

The declaration first states that infant and child mortality rates remain high in relation to the development agenda of the time, the Millennium Development Goals, and then links this outcome with low levels of exclusive breastfeeding. Addressing this concern is stated as the top priority for the government. The government committed to increasing universal coverage of health services, strengthening district health systems, regulating the marketing of breast milk substitutes,¹⁵ providing guidelines and public education, and implementing workplace policies

¹⁵ See for example: https://www.unicef.org/southafrica/media_12088.html

and legislation in support of working mothers, among other mother- and baby-friendly initiatives. The declaration also calls on multiple stakeholders to support the response, “including government and legislators, community leaders, traditional leaders and traditional healers, civil society, healthcare workers and managers, researchers, the private sector, employers, the women’s sector, the media, and every citizen” (Tshwane Declaration, 2011).

Health leaders acknowledged that formula feeding posed a higher risk for infant mortality and by promoting exclusively breastfeeding, child mortality could be reduced. Instead of mothers being offered replacement feeding, the department committed to encouraging and supporting all mothers in exclusively feeding their infants through a variety of reforms and practices, including supporting human milk banks, and requiring public hospitals to operate under the Baby-Friendly Hospital Initiative, which was developed by WHO and UNICEF in protecting breastfeeding practices (UNICEF & WHO, 2012).

To operationalize the declaration, the Ministry of Health developed The South African Infant and Young Child Feeding Policy in 2013. The policy states, “Optimal infant and young child feeding (IYCF) is essential for child growth and development. The period during pregnancy and a child’s first two years of life . . . are considered a ‘critical window of opportunity’ for prevention of growth faltering.” However, experts observe that “breastfeeding rates in South Africa, and especially exclusive breastfeeding, remain very low.” The policy states that “perception of insufficient milk, compounded by fears of HIV transmission, marketing of breastmilk substitutes, misinformation, breastfeeding problems, returning to full-time employment without supportive structures, and lack of guidance and encouragement from health care personnel among other factors” contribute to the low rate (Department of Health, 2013). In 2012, the government also published the Regulations Relating to Foodstuffs for Infants and Young Children, which aligned with the declaration’s commitment to regulate marketing around formula. The government helped fund milk banks in select hospitals as well (Dance, 2015).

These efforts have had a positive effect. One surveillance study found that “the percentage of children under 6 months who are exclusively breastfeeding has risen from 7% in 1998 to 32% in 2016” (Department of Health, South Africa, 2017). But there is more to do. A recent study suggests that “the political will to address infant and young child feeding has been advanced and demonstrated, and a supportive environment created through commitment and capacity building. There is a need for focused action addressing adequate monitoring and evaluation of processes during all stages of the implementation of evidence-based and theoretical planning. These actions should drastically improve exclusive and continued breastfeeding and advance the health and survival of children in South Africa” (Du Plessis & Pereira, 2013).

The Department of Health has turned its attention to workplace environments in supporting breastfeeding mothers and developing breastfeeding-friendly policies. In addition, in 2016, the Department of Health, in partnership with UNICEF-South Africa, launched a campaign in support of breastfeeding. The campaign focused on pledging support from all community members and using the hashtag *breastfeed2day*. As joint efforts continue to grow, the hope is that increasing breastfeeding practices will contribute to decreasing the under-five child mortality rate from 56 to below 30 (per 1,000 live births) by 2030, as outlined by the country's National Development Plan.

Although the government has made efforts to include other sectors, such as the workplace, the initiative has been largely restricted to the health sector. A critique is that it has not been mainstreamed into other sectors of society, such as education, social development, and justice, which means that widespread social support has not been built, which complicates attitudes toward breastfeeding in public (Witten, 2017). Perhaps recognizing this critique, the Minister of Health released a statement asking for support from families and communities on the occasion of World Breastfeeding Week in August 2017, stating that “breastfeeding is a human right, not just a woman’s issue or the sole responsibility of a woman, but the protection, promotion and support of breastfeeding is a collective societal responsibility.” In the preceding year, the minister made an appeal to employers to support breastfeeding mothers in the workplace.

Breastfeeding campaigns had existed in South Africa for several decades, but in response to the HIV epidemic the government practice of distributing a 6-month supply of formula to new mothers supplanted these previous campaigns, only to be reversed and replaced with antiretroviral therapy. This suggests that the “HIV confusion” may not have been fully overcome (Witten, 2017). One study found that health workers are the most important source of information for new mothers about feeding. The authors observe that there are structural barriers to exclusive breastfeeding, such as maternal leave periods that are only a few months, inadequate workplace or public spaces, and prevailing beliefs that exclusive breastfeeding is only for HIV-exposed babies. The authors suggest that the frontline health workers can be better supported with timely information and training on strategies to educate and empower new mothers (Nieuwoudt, 2018). Another study finds that attitudes toward breastfeeding in public is the last hurdle to clear as “mothers can’t breastfeed in public without provoking angry responses” and “have been humiliated and stigmatized”(Witten, 2017).

The South African government and its citizens have made progress toward increasing exclusive breastfeeding. The progress has been supported by public declarations, policy documents, and information outreach campaigns. However, there are still barriers in policy, practice, and public perception that prevent the country from reaching its target.

Implications for Well-Being Initiatives in the United States

In South Africa we saw an initiative focused on the first years of life to build a foundation for well-being across the lifespan. The initiative was in response to surveillance data that showed concerning levels of infant mortality. The efforts to change public perception and the practices of new mothers was complicated by the conflicting messages about breastfeeding and HIV transmission that were promoted earlier in the AIDS response. The initiative had to also tackle commercial interests that sold the formula by restricting the marketing and promotion of these products. Even with these national efforts, breastfeeding rates were below target. This suggests that the clear and consistent messaging from the national government was effective at changing public perceptions to some extent, but more is needed to craft more targeted messages and empower new mothers.

Although there is evidence to suggest the approach is evolving, early efforts seemed to be confined to the health sector and mothers particularly. This may have restricted the uptake of the breastfeeding practices because social support is needed in many spheres of life beyond health care and home, such as the workplace and in public spaces. More recently, the Department of Health has appealed to the public to support breastfeeding practices, evoking the rights and responsibilities of citizens. This approach should enhance these efforts and potentially lead to higher rates of breastfeeding. The implication is that program planners in the US should complement information outreach campaigns by working to change social norms and create environments that support the adoption of positive behaviors.

The initiative is built on a rights-based framework and the global development agenda. The rationale also is supported by constitutional authority; the policy is in line with the constitution's vision that "a child's best interests are of paramount importance." Another value expressed is gender empowerment; the policy states that a "woman has a right to make decisions about infant feeding on the basis of full information, and to receive support for the course of action she chooses." This framing of the response should provide entry points for line ministries and civil society to support the initiative. This example shows program planners how to involve more stakeholders into well-being efforts.

The example in South Africa highlights some considerations for program planners in the United States. The example shows how to address public perceptions when the science and guidance change over time, although social norms can be slow to follow. This example suggests that to change perception and practice for well-being may require leadership, authority (e.g., from the constitution and conventions), consistent messaging from frontline experts, and broad public support. Although these efforts have been effective at changing the behaviors of mothers, the broader public has not come as far along to support them as needed. It is difficult for mothers to adopt a behavior if there is social stigma attached to it. This finding suggests that behaviors

in support of well-being are partially about knowledge and services but also about supportive environments, which are required together for well-being behaviors to be fully realized.



Other Developments in Child Well-Being

Since we began this study, we have noted recent developments in well-being initiatives that complement the lessons from the country examples. We provide a short review here to offer some further guidance and draw implications for child well-being program planners in the US.

The most recent budget put forth by the Labour party coalition government in New Zealand prioritizes funding for mental illness, domestic violence, and child poverty and is dubbed the world's first "well-being budget" (AingeRoy, 2019). Similarly, the government of the United Arab Emirates (UAE) launched a National Programme for Happiness and Well-Being. The initiative is led by a minister and "aims at designing new ways to adopt a healthy and active lifestyle, identifying the main challenges facing the society in this regard, and raising the community awareness on healthy living and its impact" (National Programme for Happiness and Well-Being, 2019). These examples provide examples of how governments can prioritize well-being by making it the foundation for government action, as expressed through the budget.

The well-being lens can be applied to programs as well. In Jamaica, the University of the West Indies conducted a program to address sickle cell disease, a disorder affecting blood flow to limbs and organs that can affect cognitive development. Program staff developed an approach that used the disorder as the base for a broader well-being intervention that includes health education, stress management, and methods for creating a supportive home environment for child development. This suggests that holistic approaches are possible even in lesser-resourced environments.

In France, the government identified income inequality as a major hindrance to child well-being,¹⁶ which affects nearly 3 million children according to their estimates. The government launched a national strategy to tackle child poverty in 2018 involving several ministries and departments. The strategy commits agencies to social investment by creating opportunities for families to break the cycle of poverty, to guarantee the rights of children, and to offer training and a route to employment for young people. An inter-ministerial delegate was appointed to lead efforts across these agencies for such activities as creating tens of thousands of day-care centers, increasing school feeding programs by 150%, creating 170 social centers in priority neighborhoods, and promoting other approaches to prevent and respond to child poverty. This example demonstrates the importance of inter-agency collaboration to address systemic and intractable social concerns.

The government of eSwatini (formerly Swaziland) made significant progress in child well-being in the past 10 years. In 2008 the country ranked 51 of 52 countries in Africa on the Child-

¹⁶ See: *Strategie Nationale de Prevention et de lutte contre la pauvrete.*

Friendliness Index, conducted by the African Child Policy Forum. In the latest administration of the survey in 2018, the country jumped to ninth place. Spurred in part by the index rankings, the government launched the Children’s Protection and Welfare Act to align with international standards for children’s rights. Children now have better access to health care, better sanitation facilities, and better legal protection. This development demonstrates that national rankings and publicly available data can spur leaders to act positively, with success.

One of the most noteworthy initiatives in this area is Bhutan’s Gross National Happiness Index,¹⁷ a pioneering way of viewing the lives of people. The index started 2008 in response to the limited economic measures such as the Gross National Product. The index explores measures of psychological and spiritual well-being, health, education, time use, cultural diversity and resilience, good governance, community vitality, ecological diversity and resilience, and living standards to provide a more accurate picture of the human experience. The national government uses the results of the index to identify priorities to improve social cohesion and national happiness. Similarly, a coalition of organizations, alliances and leaders formed the Wellbeing Economy Alliance in Scotland, which strives to promote the “idea that economy should serve people and communities, first and foremost”. Their work challenges the use of GDP as well, by looking at ways to measure and create policies and programs in support of human well-being.

These examples provide further insight into child well-being in the US. The examples of New Zealand and UAE suggests how to prioritize well-being through public policy. The example from Jamaica shows how a program can be designed with a holistic approach. This is a subtle but profound shift shows how a well-being lens can be applied. The example to address child poverty in France suggests the importance of inter-ministerial collaboration, which has implications for any public administrative unit mandated with addressing interconnected issues that go beyond a single remit. Both Bhutan and Swaziland provide examples of how data are used, that is to collect data on what matters to stakeholders and then use those data to galvanize vision and mobilize stakeholders to collective action.

Child well-being is a holistic concept. To promote child well-being effectively requires a vision, coordination, and a common understanding on what the issues are and how success is measured. Progress in this regard is uneven in many contexts. The examples in this section offer some guidance on a better way forward.

¹⁷ See for example: *A compass towards a just and harmonious society, 2015 GNH survey report.*



Conclusions

This section presents the major conclusions of the study. These conclusions concern developing well-being as a holistic concept, addressing income inequality, creating shared values, changing norms, engaging citizens to effect change, and a creating a culture of health. These conclusions inform the implications and recommendations that follow.

Well-Being as a Holistic Concept

Our approach to child *well-being* for this study is based on the idea that five domains are critical to conceptualizing children's well-being holistically: physical, psychological, cognitive, social, and economic (Pollard & Lee, 2003). As we stated in the introduction to this study, well-being is the result of different domains coming together into a whole. Measuring a single condition obfuscates the interconnective nature of well-being. For example, we can look at PISA scores to gauge attainment in areas assessed in education; yet, we know that children need to be physically safe, psychologically supported, socially included, and economically secure to be cognitively engaged.

However, we found that the measures of well-being, such as the Better Life Index (OECD, 2019), do not use holistic measures but rather composite scores of individual measures. Child well-being is beyond the sum of the constituent parts. In other words, the conditions are necessary but are not sufficient for child well-being. Although indexes and measures of conditions can advance well-being, more needs to be done to better empirically understand, track, and support actions that promote well-being holistically and create systemic change in all the countries we reviewed.

There are some examples emerging where well-being is the explicit aim, such as the well-being budget in New Zealand, and where well-being is the implied unifying approach to education and other sectors in Finland. In the main, programs and policies are narrower in approach. The implication is that, for child well-being to advance, we need not only to understand the singular conditions but also to understand how to make sure that child well-being is more than the sum of these conditions and that well-being can be achieved for all children. Children need to be well physically, psychologically, cognitively, socially, and economically.

Income Inequality

We found that, even though there are some relative strengths, all countries have room to improve child well-being. Inequality and social exclusion are significant problems affecting well-being in some way in all the countries we studied. Children from economically disadvantaged backgrounds feel a lesser sense of belonging at school than their economically advantaged peers in Canada, and income inequality is growing in the country. Similarly, non-native-born children in Finland feel less of a sense of belonging than native-born children. Bullying is an

acute problem for children in Australia, Japan, and Brazil. School enrollment is lower in South Africa for rural and economically disadvantaged children. The wage gaps are relatively high by gender in Japan and Finland compared to the OECD average.

Both Australia and Canada provide good examples of steady and positive gains in indicators for health. At the same time, both countries offer a warning. School climate is an area of concern in which incidents of bullying are above the OECD average and the measure for a ‘sense of belonging at school’ is far lower for students who are economically disadvantaged. Income inequality is growing in both countries, which can exacerbate the problem. Finland’s conditions were generally above the OECD average, though we found that some indicators in education were trending negatively, especially for boys and Finns of lower socioeconomic status. In Japan, although children reported the strongest sense of belonging at school among our cohort, bullying is a significant problem, one that is linked to youth suicides. This finding suggests that though social exclusion can be relatively rare, it can also be acute with severe consequences.

Thus, we found that even in better-resourced contexts, disparities are developing. This finding suggests that the conditions for well-being are dynamic and can move in any direction and require stakeholders to renew commitments and update approaches to achieve the best conditions for children. Conversely, in South Africa, the indicators for the health and education areas are on the rise. The response to the HIV pandemic, for which South Africa is at the center, is showing positive results because the country is on track for eliminating mother-to-child transmission. These findings suggest that even in a context of deep resource constraints and pandemic challenges, progress can be made on the conditions for child well-being.

Wilkinson and Pickett (2019) demonstrated a correlation between income equality and well-being. We found that the well-being conditions were more robust in the countries in our sample with smaller income gaps, such as Finland and Japan, whereas the higher levels of income inequality in South Africa and Brazil created poorer child well-being outcomes. This finding suggests that income inequality as a factor in child well-being requires further study. For example, the OECD created the Centre for Opportunity and Equality in 2015 to study inequality to support the position of the organization that addressing inequality will lead to better well-being for everyone in a nation.

Shared Values

How do we move toward more holistic well-being? We found that the values expressed in programs may advance this concept. The sector-wide programs we reviewed include public education, early childhood development, and a national breastfeeding initiative that expressed values that are inherently holistic, such as human rights, gender equity, and whole-child development. The values expressed in these programs include collective responsibility, social

inclusion, and environmental sustainability that transcend the specific issue to embrace a more holistic concept. Shared values can guide action and inspire aspiration, and the values expressed in the programs that we reviewed can be building blocks for child well-being. These examples also suggest the importance of well-being across different stages of development, from birth to early childhood to adolescence and young adulthood.

In Australia, a critical value embedded in the framework is the recognition that ECE must address whole-child development. This includes a primary focus on children's well-being, which is enriched by experiences and conditions in ECE that are inclusive and holistic and connecting mind, body, and spirit. The Early Learning frameworks also values context (family, community, and place). The framework provides a call to action that is based both on children's rights and on the economic benefits of ECE to the country. The Child Well-Being Framework developed by a civil society organization in Australia may have re-framed child development in well-being terms (Australian Research Alliance for Children & Youth, 2014; P. Dakin, personal communication, August 5, 2019).¹⁸ The framework, and the related action agenda and measurement tools, were the result of consultations with academics, service providers, advocates, government staff, young people and their families, and other stakeholders and is used to inform programs and policies. This suggest that convening experts and stakeholders across disciplines can contribute to more holistic thinking on child well-being.

In comparison to the U.S. dietary guidelines, the Brazilian dietary guidelines focus on environmental sustainability, as well the connection between eating and social and cultural dimensions. Another critical difference is a focus on human rights – Brazil asserts that a healthy diet is a basic human right and all people should have access to food. In Finland the position is that the nation has responsibility to support the right of every individual to achieve a high-quality education. The ministry of education emphasizes equity of opportunity and equality of experience, as evidenced in policies and social support programs. Inclusivity is an explicit value, as evidenced in the participatory process to design the commitment, the emphasis on collaboration in daily practice, and the focus on supportive and nondiscriminatory learning environments. Similarly, the government of Japan the government mobilizes the population in suicide prevention with a notion of collective responsibility. And, in South Africa, the government calls on rights and social responsibility to encourage breastfeeding.

We found values were focused on child rights, social responsibility, gender equity, economic efficiency, and whole child development, among others. Further, we found that values in support of well-being can be expressed through human rights–based approaches while calling for collective responsibility and action. Responses can convey respect for cultures, persons, and

¹⁸ Personal communication with Penny Dakin, Australian Research Alliance for Children & Youth, 5 August 2019.

the environment. They can be supported by international conventions and by the national constitution. Additionally, responses can call on members of the public to make changes for the long-term benefit of themselves and of their family, community, and country and instill the idea to embrace change and to adapt to new challenges and changing times. We conclude there are many ways to value child well-being and explain that values can be entry points to advance child well-being initiatives in the United States.

Norms Change

How do norms change to support these values then? We found two ways. First, we found that norms change because of society-wide forces that create new dynamics and pressures on well-being. These forces, such as the changing labor and housing markets, creates the norms change. This includes the structure of the family and the division of labor at home and in the workplace. Therefore, to promote social norms in support of child well-being, policy and program planners need to understand that norms are constantly changing because society changes as do the diverse experiences of individuals and the networks where they make meaning and reinforce behaviors.

Second, we reviewed examples of interventions designed to intentionally change norms. The South Africa example shows that targeted outreach through health professionals and clear and consistent messaging from the national government can effect change at the family level. However, for well-being behaviors, such as exclusive breastfeeding, to be fully adapted requires supportive environments in the public and workplaces.

A common strategy for many of these norms-change interventions was to present information that shows how peers behave, or what family and community members experience, and use this information as a departure point to spur discussion and self-reflection and to inform actions. This was one of the strategies for tobacco use prevention in Canada, for example. We learned from the norms change research that change can happen when situations are made more transparent, such as the through the *social norms approach* to norms change where misconceptions are corrected and a better understanding of the conditions of others is developed.

Several of the intentional interventions we reviewed underscored the need to develop empathy and understanding in populations as a basis for norms change. This finding was true for interventions in schools, in communities, or among peers. Therefore, to purposefully change norms, we see that it is important to tell the human story with attention to variation as well as commonality so that people know how their peers and family members are affected by the prevailing social norms. We found that empathy and understanding can be developed through interactive and dialogue-based interventions and social norms approaches that address the

gaps between perceptions and behaviors. Social norms can be implied or imposed by institutions or society. When these norms are made explicit, stakeholders can understand the motivations, desires, and consequences of others in their group or community. This is a powerful starting point for changing norms. This approach may require more comprehensive, accurate, and real-time information so that these stories are described in context and in a compelling way. This finding offers a clear direction for program designers and the journey from me to we may begin there. For example, some common themes in the programs we reviewed told the stories of individuals, families, communities, and populations. By sharing their conditions of well-being, we can foster empathy. Then by shedding light on the systems that contribute to these conditions (Erwin, 2017) and by demonstrating how the action of each citizen affects another citizen, individuals can make the connection to their daily lives and call for collective action in defense of rights, equality, and social inclusion. These programs showed that increasing one's understanding of the environment and identifying harmful norms form the foundation for positive social norms change.

One force that did not come up in the well-being norms change review but that may profoundly affect well-being norms is climate change. Klinenberg et al. (2017) predicted that climate change will have dramatic health effects, especially for populations who are disadvantaged. It may also drive internal and international migration with its attendant problems. Therefore, climate change has the potential to create new norms as families respond to its effects. This issue warrants close study. We agree with Abbott and D'Ambruoso (2018), who stated that social change calls for new ways of addressing well-being. A first step toward this new way may be to understand how norms are changing because of social and physical forces and appreciate the effect they have on individuals, families, and communities.

Through this study we have identified values that promote well-being and how norms can change in support of well-being. We also discovered many examples of calls for collective responsibility to promote well-being. It is at the intersection of these two points—holistic approaches and collective action—that we discover a lever for change.

Citizen Science

New methods and technologies are emerging that allow more individuals to contribute to the collection and use of information that affects their lives. Big data, real-time data, social media, machine learning all present the opportunity for a new way of collecting and using data by more people—life beyond the spreadsheet. For example, citizen science (Mehta, 2017) is a method for personal learning that “promotes a culture of health at the individual level” by making science accessible.

Throughout this study we have seen examples of governments and citizens using data at the global and personal level to effect change, such as suicide prevention in Japan, tobacco use prevention in Canada, and child welfare in Swaziland. We found that institutions are also undergoing norms change as reflected in the work by the OECD and other international agencies. The example of Japan demonstrated that it is important to adapt programs to the local context, but at the same time guidance and standards are critical for successful implementation. These changes are opening up new opportunities for emphasizing data and more inclusive civic engagement.

Modern public service is evolving to address modern demands, including child well-being. Norms have changed within intragovernmental relationships as well as the citizen-government relationship toward increased collaboration and collective problem solving, an approach that is necessary to address the intersectoral nature of child well-being. This development offers a new opportunity to promote child well-being by accelerating information exchange between citizens and government that can contribute to more responsive programming. To make the most of this development, administrators and citizens need data that are accessible and actionable, as well as to develop their joint capacity to engage each other and involve people in the process who have been traditionally excluded. Thus, policy and program planners should prepare public administrators to engage with citizens and civil society and to work across sectors to address the interconnected conditions that support child well-being.

The OECD's Better Life Index (2019) and other efforts by intergovernmental agencies, such as the Commonwealth Secretariat, are bringing more attention to the importance of well-being and cross-national comparisons. And, the Wellbeing Economy Alliance (n.d.), which works "to change the economic system to create a wellbeing economy: one that delivers human and ecological wellbeing." But we may need new ways of generating and using data that tell the story better—that is, holistically, such as the example of Bhutan. As programs become more holistic, they may take longer to show results. Therefore, longer time frames than programs are generally afforded may be necessary.

In sum, citizen science may offer new opportunities for understanding how people live, what affects them, and how to better measure and shape interventions to promote their well-being.

Culture of Health

How do we move from the "me" to the "we" to promote a culture of health for child well-being? The Brazilian dietary guidelines incorporate a "we" mindset in that food is viewed within the context of family, community, and culture. The example from Australia in this study demonstrates how to address well-being in the early childhood stage of development, how to

establish healthy relationships between children and teachers and staff, and how to provide a rationale for action that is mutually beneficial to individuals and the nation.

A culture of health is best embodied when well-being is the lens for decision making (Canadian Index of Wellbeing, n.d.). These can be achieved at the program level such as the example from Jamaica where the University of the West Indies implemented a program that shows that in resource-constrained environments, holistic approaches are possible. This can also be achieved at the national level where well-being aims are driving cross-sectoral collaboration, such as France's Inter-ministerial effort to tackle child poverty¹⁹. We have an example from Australia: well-being can be the metric that everyone works toward, operationalized as "being, belonging, and becoming" (not test scores); a focus on the "transparency" of well-being is what makes Australia's approach unique (Erwin, 2017).

Recent work by the epidemiologist Sandro Galea (2019) explores the issue of well-being in the United States. He identifies barriers to the conceptualization and the discourse around health that prevent programming in support of well-being holistically. These include that health is often conflated with health care; how health status is often talked about as the product of individual choices rather than the conditions and factors that affect everyone; and how the system supports the narrow self-interest of individuals rather than a supporting a rising tide that lifts all boats. The author states that there are "contradictions inherent in the American idea of freedom – this tension between maximizing individual freedom and protecting the well-being of citizens -- reflect how are understanding and application of freedom is a central determinant of our ability to live safe, healthy lives" and that the "America insistence of total individual freedom has led us to invest too little in the policies and institutions that promote health, undermining our well-being and diminishing our freedom". The author concludes that we need compassion and justice; a political vision that offers a counter narrative.

We conclude that for child well-being to advance in the United States and elsewhere, there must be a shared vision for well-being. Individuals must see the worth in well-being interventions on a values level as well as on a practical level. Well-being programs can deliver on fundamental human rights (for health and education, for example) but also make good economic sense as the health consequences for children will be costly over their lifetime. But conversely, the benefits can ramify across the individual lifespan and society broadly. Citizens should also understand the ecology of well-being: how the systems, conditions, and our interactions affect one another in different ways and how the systems and structures have been unjust to many people.

¹⁹ See for example: <https://lesprosdela petiteenfance.fr/formation-droits/les-politiques-petite-enfance/plan-de-prevention-et-de-lutte-contre-la-pauvrete-des-enfants-et-des-jeunes>; and, <https://www.gouvernement.fr/strategie-de-lutte-contre-la-pauvrete-plus-on-intervient-tot-plus-on-est-efficace-sur-le-destin-des>

To understand well-being is to understand relationships, connectivity, and ecology, and thus to understand that one's well-being depends on others and, conversely, that one's actions affect the well-being of others. Thus, to advance a holistic idea requires people to work collectively. To make the system work for everyone requires an active and engaged citizenry armed with data and tools to decide the best way forward.

Implications

How do we move from the 'me' to the 'we' to promote a culture of health for all children's well-being? We complete this study by drawing the following implications for practice and policy that can be acted upon by planners immediately and over longer time frames:

1. Address the causes and effects that income inequality has on child well-being.
2. Promote rights-based approaches to child well-being and emphasize values such as equity, inclusion, and social responsibility.
3. Raise awareness on the ecology of well-being: how the systems, conditions, and our personal interactions affect one another in different ways.
4. Design programs that increases everyone's understanding of their environment, historical in-equities, and the norms that influence behaviors; and, demonstrate how individuals can contribute to child well-being.
5. Explain how the benefits of child well-being can ramify across one's own lifespan and across society generally.
6. Understand how norms are changing because of society-wide forces and appreciate, and respond to, the effect they have on individuals, families, and communities.
7. Promote a counter-narrative to the atomized individual – one rooted in justice and compassion – on the public policy agendas of different levels of government.
8. Use well-being as the unifying objective for cross-sectoral collaborations to break down silos between agencies, disciplines, and other stakeholder groups.
9. Utilize new methods and technologies that afford individuals and groups the chance to contribute to the collection and use of information that affects their lives – and provide appropriate capacity development so that marginalized persons have equitable opportunities to contribute.
10. Create new epistemologies for well-being: measure programs on longer time frames, as programs become more holistic, they may take longer to show results; develop metrics that go beyond the narrow measures of single conditions and simple binaries; prioritize developing methods to collect subjective measures of well-being for a wide age range of children so that their voices are represented.

11. Convene experts and stakeholders across disciplines who can contribute to more holistic thinking on child well-being, by developing frameworks, action plans, evidence, and tools.
12. Designate authorities with the mandate to work across public administrative sectors to coordinate efforts, harmonize approaches, and employ resources effectively for the benefit of child well-being.

Our concluding theory of change is that if more people are inspired to think holistically, have the capacity and opportunity to engage in change, are driven and supported by values and norms that contribute to a healthy and equitable society, then child well-being will be a realized American value.

Limitations

This study is based on a literature review of governmental documents, peer-reviewed journal articles, books, program reports, and websites. The limitations of this study include the lack of systematic reviews of the literature that provide an exhaustive summary of the evidence on norms change or rigorous research studies showing the casual links among the interventions, policies, norms change, and outcomes. There are also differences across studies, interventions, and policies in measuring well-being. Furthermore, our comparative data sources were at the national level and we did not discuss subnational findings because we found limited or inconsistent disaggregated data from the six countries in our sample. Our use of national-level information may mask critical variations within each country that occur among and within groups because of geography and region, demographic factors, sexual orientation and gender identity, socioeconomic factors, positions of privilege versus marginalization, and internal and external migration patterns. Other factors that impact children’s well-being that we did not study include political and historical factors that underlie well-being as well as inequities in children’s experiences and the determinants of well-being.

Another limitation of this study is the exclusion of lower income countries from our sample of six countries. Our sample consists of upper-middle-income countries (Brazil, South Africa) and high-income countries (Australia, Canada, Finland, Japan). Because this study relies on literature and extant data sources that are publicly available, we limited our sample to “data rich” countries; developing countries have a limited capacity to invest in data collection.

Future Directions

Future directions for this project can include facilitated sessions with RWJF and stakeholders to consider and think deeply about the lessons learned from our sample of six countries and implications for efforts to promote children’s well-being in the United States. Because we examined national-level findings and data, this project does not permit examination of within-

country differences. The next step in the line of research used in this project would entail interviews with several key informants in each country of the study sample and in-country fieldwork to make the connections among political and historical factors, the subjective perceptions of children and families, and objective outcomes. Fieldwork also would allow us to collect primary data from subgroups to examine disparities at subnational levels. In addition, collecting data directly from children and their families would result in a more nuanced understanding of children's lives by providing information from multiple perspectives and from vulnerable groups that may not be included in national-level studies. Future directions for this research would include data collection from governmental and nongovernmental organizations that serve children to learn practical, on-the-ground details about countries' and communities' efforts to address disparities in children's well-being. Such an approach will afford researchers a better and deeper understanding of the lived experiences of children and families that cannot be gained from secondary sources alone.

The WHO and the UN have recognized that a lack of accurate and reliable data, especially disaggregated to subnational levels, prevents researchers, policymakers, and practitioners from identifying and understanding vulnerable groups that often are not counted in household surveys or by other data collection methods (Bartolomeos, 2018). Inadequate data prevent accurate tracking of progress on development goals and challenge governmental and nongovernmental organizations' abilities to address disparities in children's well-being. Advocacy groups and others are calling for a data revolution that improves traditional data collection methods—household surveys, censuses, and government registers—and includes innovative methods (i.e., mobile phones, satellite data; Stuart, Samman, Avis, & Berliner, 2015).

This study did not examine the effectiveness of the interventions and policies we described in the six countries. At this point, we do not know whether the interventions and policies make a difference in children's lives and impact well-being. The next step to this work would entail research using rigorous designs to examine the impact of the intervention or policy on child well-being. This approach would yield better insights into child well-being and a greater understanding of what those insights might mean in the United States context.

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