Project Head Start: Denaturalizing Health Discourse in Working with "Disadvantaged Children"

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Author's Note

Xue Yin is a doctoral student in the Department of Curriculum and Instruction and in Global Studies at the University of Wisconsin-Madison. This research is revised from an early chapter of a doctoral dissertation. The dissertation historically examines health discourse in working with young children through Project Head Start. This article sets the stage for using "Empty Square-History of the Present-Discourse Analysis" as a framework to reconceptualize health discourse in Project Head Start. Based on this article, the other chapters of the dissertation research attempt to answer three more questions: First, What kind of health discourse is constructed as a regime of truth in Project Head Start? Second, what historical and epistemological conditions make the health discourse possible in Project Head Start? Third and finally, what are the effects of the discourses? Correspondence about this research should be directed to Xue Yin, email: xyin32@wisc.edu

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Abstract

Using Project Head Start as an example, this article argues that "health" is not a neutral notion, but that the good intention of changing "health" disparities could reinforce structural inequality. Firstly, this article reviews the dominant mode of Head Start studies on health, the research *for health*. Secondly, this article denaturalizes health discourse by sketching three layers of theorization of "health" and their implication for education: the opposite of diseases, the mechanics of normal and pathological, and the discipline of daily life. Building on this, this article explores the possibility of an emerging territory of Head Start studies, that is, the research *of health.* Through the lens of biopower, this research directs the question from "What is health" to the focus on the subjectivity, power circulation, and knowledge production of health practice. This article contributes theoretically and methodologically by denaturalizing health discourses to reimagine the practice of working with "disadvantaged children."

Introduction

One of education's essential goals is raising healthy children. The new initiative of UNESCO, Making Every School a Health Promoting School (2024), aims to promote global standards for health-promoting schools. While a significant amount of research explores strategies to educate healthy children or to improve children's health (Hoagwood et al., 2021; Zajacova & Lawrence, 2018), some worry about the danger of "health": how health becomes "a juridical-religious obligation that must be fulfilled at any cost" (Agamben, 2021, p. 8) or the new health imperatives on young children across different countries (Wright et al., 2012). In early childhood studies, research has investigated the "at risk" discourse, which has inscribed structural inequity in medical and public health (Swadener & Lubeck, 1995). This article and my

research into health joins this ongoing conversation by investigating Project Head Start.

As the most extensive nationwide early childhood education program in the United States, Project Head Start was initiated in 1964 within the social context of the anti-poverty campaign. It was initiated to support "disadvantaged children" to improve the socioeconomic situations of the children, their families, and their communities through educational processes linked with the school (Zigler, 2010). Since its initiation, Head Start has been considered a multi-service component program that includes early childhood education, parent involvement, nutrition, social services, mental health services, and health services. The health component has played a significant role throughout the development of the program. On the first Planning Committee, five people had medical backgrounds, three were psychologists, two were early childhood educators, and one belonged to a social work profession (Zigler, 2010). As a case of Compensatory Education, Head Start was criticized as an image of the deficiency model education policies aimed at working with "disadvantaged" children and their families (Beatty, 2012). The history, influence, and complexity of Head Start make it a compelling case for informing policies and practices in working with "disadvantaged children" when the aim is to do so by addressing health issues.

This article argues that Head Start is not just a program that supports "disadvantaged" children but also an expression of health discourse that manifests how biopower works. Firstly, it reviews the mode of studies on children's health as an aim of Project Head Start, which I referred to as research *for health*. Secondly, drawing on Foucauldian studies of health discourse, this article deconstructs the notion of "health." It demonstrates the complexity and potential for exploring multiple layers of theorizing about fabricating the term and meaning of "health" and the implications for childhood studies and education policy studies. Thirdly, this research reconstructs the possibility of an emerging territory of childhood studies and education policy studies, that is, the research *of health*, directing the question from "what is health" to the focus on the subjectivity, power circulation, and knowledge production of health policy and practice.

Research *for Health* and its Limitations

Existing Head Start studies have focused on health. Most of the literature belongs to what I call research *for health*, which takes health as a predetermined notion conceptualized by biomedical studies and works as one of the educational goals. The core object of research *for health* is to explore how to improve certain populations' health through different practices such as teaching healthy knowledge (Byrd-Bredbenner et al., 1993), setting up healthy environments, nurturing healthy behaviors (Gable & Lutz, 2001), and preventing unhealthy behaviors—these conventional ways of looking at health share a similar logic that could be summarized as follows.

Firstly, the connection between health and Head Start has been explored from different perspectives to justify that health is one of the primary goals of Head Start, which makes Head Start different from other preschool education programs. Historically, for instance, Catherine J. Ross argues that the Head Start program "echoed past experiments" in which "public and private agencies had repeatedly attempted to eradicate poverty through early intervention in the lives and education of poor children." (Ross, 1979, p. 21) Maris Vinovskis traced Head Start in the historical context of the 1950s to 1960s. He argued that although there were debates about its primary goals, health was a key focus in the policymaking of Head Start as a means to combat poverty. Poor health was examined as one of the factors contributing to poverty in America. Vinovskis shows that Head Start was viewed as a

program that was perceived as providing comprehensive health, social, and educational services to the disadvantaged (Vinovskis, 2005). Edward Zigler's team examined the intentions and backgrounds of Head Start's founders. It was noted that the Head Start planning committee's recommendations were based on a "whole child" philosophy that embraced several areas: nutrition, physical and mental health, parent involvement, social service for families, and early childhood education." (Zigler, Styfco, & Gilman, 1993). The Head Start program was compared with other early childhood education programs, such as the Perry School preschool program (that was used to expand into the High Scope Model in later years), to show that health services in Head Start make Head Start unique (Zigler & Styfco, 1994). Researchers also argued that, within the Head Start program, the health service was considered to play a more fundamental role in supporting poor children than academic success (Kalifeh et al., 2011).

Secondly, certain images of children, their families, and communities are portrayed as subjects needing to be changed. Head Start's target population includes children and their families who are classified as disadvantaged. For example, Zigler found that Head Start reached "its target population," i.e., most of the families are poor, minorities, single parents, and disabled (Zigler, 1992). Federal guidelines require that at least 90 percent of the children served should be from families whose income falls below the poverty lines, and at least 10 percent of enrollment must consist of "handicapped" children (Zigler, Styfco, & Gilman, 1993). The health conditions endured by target children and families include "inadequate prenatal care; maternal substance abuse; infant mortality; low birth weight; lead poisoning; AIDS/HIV; poor nutrition; inadequate immunizations; and lack of access to adequate health care."(Edward Zigler et al., 1994, p. 515) This seemingly neutral descriptive language constructs the situation and urgency of changing the health of children, and the need to make a difference.

Thirdly, the existing research portrayed how Head Start should and could work to make a difference by promoting the target population's health. To conquer poverty and solve the "problems," children's health becomes the main focus. Health is conceptualized as medical standards and domains through a "detect-remedy-prevent" model. For example, the health component is codified in the goal statements of the *Head Start Manual of Policies and Instructions* in 1967:

> "…to improve a child's present function by finding all existing health defects and remedying any existing defects; to ensure a child's future health by providing preventive services, improving the health of all members of the child's family, and improving the health of the community in which the child lives through." (Office Of Child Development, 1970)

This "detect-remedy-prevent" model persists and is enshrined in various iterations of Project Head Start Performance Standards and other official papers.

Finally, evaluation has been a significant element of Head Start. Evaluation is not just strong evidence supporting the debate about whether Head Start should exist (Carneiro & Ginja, 2014; Currie & Neidell, 2007; Ludwig & Miller, 2007). It also becomes a key point that affects how Head Start functions. As Zigler puts it, "It is possible that if the evaluation had achieved its proper role, most of the unfulfilled promises of Head Start health services would have been fulfilled." (Zigler, 1979, p. 249).

The primary reasoning of research *for health* on Head Start is a closed system involving four steps: proving the close relationship between health and Head Start, constructing the subjects that need to be changed, laying out strategies Head Start could do to make a difference, and evaluating whether Head Start had made a difference or not based on the primary objectives they had laid out. In this logic, "health" was taken as a predetermined notion. Firstly, this way of approaching "health*"* did not show the historical complicity and the ambiguity of its conceptualization, despite highlighting health as the goal of Project Head Start and students' health as the precondition of making a difference. Secondly, it did not show us how a certain conceptualization of "health" works as a normative notion that disciplines how we conceptualize childhood/s and education. Thirdly, the rationale fails to explore the discursive strategies of health that contribute to framing "disadvantaged children" as issues in need of intervention and change. This unsettling the *for health* approach propels this article and me, the author, to examine the entanglements of "health" with education reforms. In the following section, taking cues from Foucauldian studies on health, I aim to show the complexity of the conceptualization of "health" and its implications for education.

Research *of Health*: From "What is Health" to "the Experience of Health."

This article focuses on the research *of health*, an emerging territory that draws on different theories to unpack the notion of health and make visible the effects associated with the normative use of health. Although these investigations extend beyond Head Start studies, this study extends two key lines of inquiry. Firstly, I focus on the researchers who challenge taking health as a predetermined, neutral concept. For example, Patrick Bühler and Michèle Hofmann's research shows that the definition of health was associated with the conceptualization of disease and (ab)normality (Bühler & Hofmann, 2017). Denise Maria Gastaldo argued that health is "not merely a physical experience but is also a discourse that selects people as possible 'contributors'-or not-to its construction." (Gastaldo, 2002) Secondly, scholars also explore the productive power of health as a normative notion in the formation of the subject (Kirchgasler, 2018; Kirchgasler, 2022; Ziols & Ghosh, 2022; Ziols & Kirchgasler, 2021).

Research *of health* is an emerging territory in the sense that it exists only through scholars' concerns, questions raised, and the methods adopted. As Despret and Morrison put it, "Territories exist only through actions."(Despret & Morrison, 2021, p. 125) Drawing on Foucauldian studies, the following section engages this territory by investigating the conceptualization of health as an attempt to deconstruct and the inspiration of biopower as a theoretical framework for reconstructing.

The Conceptualization of Health: From the Opposite of Disease to the Cultural Assemblage of Normal-Pathological

Canguihem takes health as a notion of normalization through which a certain exercise of power is founded and legitimized, and the discourse of qualification and correction becomes possible (Canguilhem, 2012). Foucault's work further discusses health from two dimensions: health as the opposite of disease and the cultural assemblage of the normal and the pathological.

For example, in *The Birth of the Clinic,* Foucault articulates the relationships of various forms of medical knowledge pertaining to the positive notions of "health" and "normality."

> "Medicine must no longer be confined to a body of techniques for curing ills and of the knowledge that they require; it will also embrace a knowledge of healthy man, that is, a study of non-sick man and a definition of the model man. In the ordering of human existence, it assumes a normative posture, which authorizes it not only to distribute advice to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives." (Foucault, 2012, p. 34)

The main takeaway from Foucault's remark on the relationship between health, disease, and normality is the shift of health as the opposite of disease, which he refers to as "qualities of vigor, suppleness, and fluidity, which were lost in illness and which it was the task of medicine to restore', to the "normality," which refers to the 'regular' functioning of the organism (Foucault, 2012, p. 34). This research argues that change from the opposite of disease to normality implies the relocation of power. As the opposite of disease, health was considered a description of the body's condition, which is naturally connected to organs. This bio-foundational premise implies innocence and authority, as evidenced by the assertion in Head Start that nobody would be against improving the health of poor young children. However, the conceptualization of health is ambiguous. The shift in focus towards normality allows "health" to extend beyond describing the qualities of an organization. It becomes the standard for defining right and wrong in organizing life, as well as a general form of existence and behavior. In other ways, it becomes a domain of power apparatus in governing the population through organizing how to live. Just as the major vector of the problem of abnormality drifted from "the cannibalistic monster of the beginning of the 19th century to most elementary and everyday conduct since the end of the 19th century" (Foucault, 2003). Pursuing "health as the normality" has also shifted to daily practice. This transition makes it possible for schools and daycares, as daily institutions, to become sites of making the politics of health an apparatus of normative power.

The theorization also accounts for the changing conceptualizations of health throughout Head Start's history. Just as particular language is legitimized as truth in a given time and space to describe the disease, the medical language of health is based on the temporary epistemology of body and disease. This reminds us to be cautious of taking health as a predetermined notion of articulating the goal of Head Start without locating it in a specific time and space. Therefore, the goal of "making healthy children" in Head Start must be examined historically. But to explore historically doesn't necessarily mean tracing back the history and justifying "health is the authentic goal of Head Start;" rather, in drawing on Foucault, historical exploration is to examine how the continuity and discontinuity of rational and historical conditions of conceptualization of health, within this goal of "making healthy children," is reasoned throughout the Head Start program.

Foucault's exploration promotes a reflection on the rationale behind prioritizing students' health within the Head Start Program. He underscores a shift from merely aiming to produce an optimal number of children to the proper management of childhood itself: "It is no longer just a matter of producing an optimum number of children, but one of the correct management of this age of life." (Foucault & Gordon, 1980, p. 172) Foucault also highlights the role of hygiene and medicine in social control.

> "This program of hygiene as a regime of health for populations entails a certain number of authoritarian medical interventions and controls…Nineteen-century politico-medical (was) hedged in by a whole series of

> prescriptions relating not only to disease but to general forms of existence and behavior (food and drink, sexuality, and fecundity, clothing, and the layout of living space)."(Foucault & Gordon, 1980, pp. 175-176)

These points prompt an examination of how medical professionals exert authority within the Head Start program and how the concept of "disadvantaged" children is fabricated, functioning as a tool for social reform in education.

As we can see from the analysis, the conceptualization of health is complicated. Foucault's examination provides a way of exploring three layers of health: (1) The conceptualization of health defined as the opposite of disease, (2) The conceptualization of health as the normative way of living, and (3) The daily institutions, the authority of medicine, and practices of subjects that make "health" discourse possible in education reform. If we use this theoretical framework to investigate Project Head Start, we explore health discourse beyond the notion of "health" but work on the positions occupied by "health" and other similar notions and "the play of analogies and differences as they appear at the level of rules of formation" (Foucault, 2013, p. 178). This resolves the methodological issue of determining where to draw the line for defining "health." For instance, Project Head Start documents (Office Of Child Development, 1970) prioritize "Health Services," which refer to "the medical services/resources accessible to the students." Other services like "Nutritional Services," "Mental Health Services," and "Social Services" may or may not explicitly reference "health," but they collectively contribute to the overall concept of health within Head Start.

Biopower: Three Axes of Experience of Health

Foucauldian studies on health provide a theoretical possibility of exploring the conceptualization of health discourse in Head Start. Biopower theories provide insights into the research *of health* by exploring the possibility of switching the questions from "What is health?" to "What are the practices of health in biopower/biopolitics?" The central focus on health discourse in Head Start will not be to "argue with the scientific 'truths' (others have taken up this task). Rather, it provokes how these 'truths' become 'recontextualized' in different social and cultural sites to inform and persuade people on how they should understand their bodies and live their lives." (Wright, 2012,)

This article takes biopower as a "perspective" that investigates the intervention upon the "vital characteristics of human existence—human beings, individually and collectively, as living creatures who are born, mature, inhabit a body that can be trained and augmented, and then sicken and die." (Rose, 2007, p. 54). This theorization of biopower (Rabinow & Rose, 2006, p. 195) provides a methodological tool to capture the health practices of Head Start: to investigate the truth discourse about the 'vital' character uttered by certain authorities, to explore the strategies for intervention upon collective existence in the name of life and health, and to examine how the modes of subjectification become possible. These three axes of biopower have also been considered as the three dimensions of critical work: a study of modes of veridiction, an analysis of forms of governmentality, and a description of forms of subjectivation (Gros, 2010). Centering on "vital" character, the historical formation of discourses of truth, the forms of governmentality, and the modes of subjectivation are the key points of investigating health. Through the three axes of biopower, Project Head Start is approached as an event of biopolitics.

Therefore, the theorization of "health" in Foucauldian studies allows us to reframe how we ask questions. As articulated earlier, different ways of asking

questions could lead to new insights. Drawing upon the previous discussion, three layers of questions could be explored. Firstly, what kind of health discourse is constructed as a regime of truth in Head Start? To ask questions this way, instead of taking health as the taken-for-granted goal of Head Start, we explore how health becomes the goal of Head Start and why we believe changing particular students' way of living could help us eradicate poverty. Secondly, in the name of "health," what apparatus and strategies have been naturalized in Project Head Start to govern and intervene in the population? Thirdly, what kind of subjects are made possible as "Head Start children"? What are the forms within which individuals are able, or obliged, to recognize themselves as subjects of this health? Instead of naturally taking "Head Start Children" or the changing narratives as "disadvantaged children," "at-risk children", "lower class children" "Low-income children," "Culturally Deprived children," or "Underserved children," this perspective urges us to explore how these narratives are formed and what are the assumptions, expectations for individuals known as "Head Start children" and their parents, as well as their communities' way of living.

Project Head Start: "Poor" as the "Problem" and "Poor Health as the Problem of the Poor"

Head Start was initiated in the Civil Rights Movement, targeting "poverty." The problem that Project Head Start is facing is the poverty of children, their families, and communities. The main goal of Head Start is to provide a future for poor kids (Horvath, 1969). One of the strong beliefs is that the images of the poor relate to ill health. Poor health is one condition that makes "poor" people become a problem. As the following texts articulated,

> "The Head Start Planning Committee, one in which physicians were heavily represented, recognize that poor health might be a particular problem for the low-income children served by Head Start, both because such children might be expected to have more health problem than middle-class children and because they would be less likely to have obtained the services necessary to prevent or remedy them." (Zigler, 1979, p. 231)

As the text shows, poor children are considered to have more health problems and need to have services to prevent and remedy the problem. Therefore, for Head Start, to solve the problem of the poor is to solve the problem of poor health. This leads to the focus of Head Start in Health. As Zigler puts it,

> "Ill health is one of the burdens that can keep a child from fully making the most of his or her opportunities. Health and its prerequisites, such as nutrition, must be a major concern of any program aimed at augmenting child development" (E. Zigler et al., 1994, p. 231)

Two layers of health conceptualizations have been intertwined together in the text. The first layer of "health" is the medical services to "prevent and remedy the problem," and the second layer of "health" extends its territories out of medical service works as a prerequisite for children's full development. This layer of health is more than a medical issue. It becomes a strategy of how to organize students' daily lives. The children's body becomes the site for articulating the desire for reform. These two layers mutually justify each other together to support the statement of first health as the problem, the goal, and the contribution of Head Start. Through these two layers of conceptualization, health, as the effect of structural inequity, becomes the site of problem and intervention.

The economic poor and biological health problems are portrayed as the conditions of the Head Start children and their families. The relationship between poverty and health has been investigated (Blackburn, 1991; Raz, 2013; Reading, 1997; Sarche & Spicer, 2008) very thoroughly. This article did not focus on whether poverty causes health problems or health problems cause poverty. It argues how Poverty-Health works together in the construction of "our present biocentric conception of the human, as well as its related 'formulation of a general order of existence." As Wynter argued,

> "A parallel and interlinked role is also played by the category of the Poor, the jobless, the homeless, the "underdeveloped," all of whom, interned in their systemically produced poverty and expendability, are now made to function in the reoccupied place of the Leper of the medieval order and of the Mad of the monarchical, so as to actualize at the economic level the same dysgenic or dysselected-by-Evolution conception." (Wynter, 2003, p. 325)

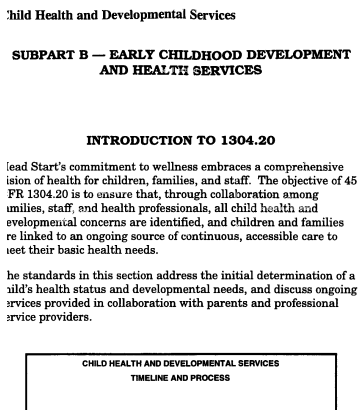
This article argues that this construction of boundaries serves as the precondition, the problems that Project Head Start is justified in solving, and the provision of services for making change. Through this process, structural inequity has been projected on the health conditions of the children, mothers, and their families.

Despite the historical concreteness of each Head Start Program Performance Standard (HSPPS), such as changes in the health service domain, medical standards, and the focal service population, throughout time, Head Start Program Performance Standards work together as descriptive statements to define what counts as healthy life. This continuity makes hierarchal differences through categories of people, transcending data, and expert knowledge as authorities of daily life experience based on the preventative logic of detecting, screening, and standardized procedures of daily routine.

Using Head Start Program Performance Standards and Other Regulations (1998) as an example, it sets clear timelines and requirements to conduct developmental, sensory, and screening procedures (45 days) and determine whether a child has a source of health care and is up-to-date, needs further testing, and follow-up plan on preventive and primary care (90 days), Seeing

Figure 1

Figure 1. This standard procedure reinscribes and produces what a student is/is not and should be/not be through the medical Lens.



:hild Health and Developmental Services

SUBPART B — EARLY CHILDHOOD DEVELOPMENT AND HEALTH SERVICES

INTRODUCTION TO 1304.20

lead Start's commitment to wellness embraces a comprehensive ision of health for children, families, and staff. The objective of 45 FR 1304.20 is to ensure that, through collaboration among milies, staff, and health professionals, all child health and evelopmental concerns are identified, and children and families re linked to an ongoing source of continuous, accessible care to ieet their basic health needs.

he standards in this section address the initial determination of a nild's health status and developmental needs, and discuss ongoing ervices provided in collaboration with parents and professional ervice providers.

CHILD HEALTH AND DEVELOPMENTAL SERVICES
TIMELINE AND PROCESS

(Head Start Program Performance Standards and Other Regulations 1998, p. 41)

Although the HSPPS emphasizes "Individualization," this "Individualization" is built upon standard procedure and expert knowledge. HSPPS (1998) "individualization of the program" is built upon "a standard procedure of screenings, observations, and evaluations, activities are tailored, the curriculum adapted, and the physical environment modified to support each child's learning style and to be responsive to differences in style." (1998, p. 55) Besides, this individualization is also specific emphasis to children with disabilities, as "most children will not require special education services to address their needs. However, children with disabilities often require a particular set of special services" (Bureau, 1998, p. 55). A similar logic could be found in nutrition service; despite the calling for individual differences and avoiding comparing students, the HSPPS (1998) reinforces data and experts as the authority on children's nutrition status, "it is important to involve a health professional or a nutrition specialist in the review of nutritional data, as well as in the development of treatment and follow-up plans." (Bureau, p. 99)

"Community" has been an important notion since the initiation of Head Start. Head Start has been considered a community movement where black feminists and poor communities fight to make their voices to be heard (Lombardi, 1990; Sanders, 2016). As Thomas Popkewitz observed, in postwar science, community is a method to "decentralize social institutions to be more responsive to the particular social groups that faced social and economic inequalities, particularly in the wake of the civil rights movement." (Popkewitz, 2020, p. 133) However, "community" quickly "transformed in the social and educational sciences and social policy as an administrative category for organizing relations of government and social movement." (Popkewitz, 2020) This means that the notion of "community" still works, but it shifts from the "political agendas to enlarge participation to foster social and cultural counternarratives" to the "administrative category." This shift also inscribed the transcending of "expert knowledge" as the authority to solve social problems by shaping a healthy daily life.

For instance, HSPPS (1998) states, "information about major community nutritional issues, as identified through the Community Assessment or by the Health Service Advisory Committee or the local health department." (Bureau, 1998, p. 100) Community is not considered a counternarrative of how to live healthily. Instead, the community's nutritional issues are identified through "expert knowledge." For instance, despite the HSPPS (1998) request to respect family eating patterns, registered dietitians, qualified nutritionists, the USDA/HHS Dietary Guidelines for Americans, and the USDA Food Guide Pyramid, Nutrition Facts Labels are considered the authority for food preparation and provision. As communities become administrative categories, children and their parents are now inscribed and constructed as in need of change, guidance, observation, categorization, and assessment, as well as attempts to standardize or make "normal."

Conclusion

One of the central debates of Head Start studies is "Is Head Start a success or failure?" (Zigler & Sally, 2004, p. 1). The answer to this question has political effects. This research suggests that how a question is answered is attributed to how the question is framed. As Gayatri Chakravorty Spivak articulated,

> "if the lines of making sense of something are laid down in a certain way, then you are able to do only those things with that something which are possible within and by the arrangement of those lines." (Spivak, 2009, p. 38)

This research asks different questions about Head Start. It does not ask whether Head Start has improved children's health or argue whether children's health should be its goal. This article unboxes the notion of "health." It denaturalizes health discourse by showing the conceptualization of health as a medical notion that embodies cultural normalization. My research into health and Head Start, and this particular article, presents a theoretical framework for reflecting on health practices in curriculum design and related educational policies in early childhood education. In the article, I encourage educators and policymakers to consistently reflect on the cultural politics of health discourse in programs that serve "disadvantaged children" by pausing and asking "whose health," "what are the effects," and "what does it add to students."

To clarify, in this article, I do not mean to discount the good intentions of Project Head Start. Head Start is considered as one part of the "rhizome" (Deleuze & Guattari, 1987) in the sense that it is an intense expression of a particular rationale: change structural social inequity by improving children's health. This rationale echoes other programs and practices. Historically, practices such as charities supporting poor children had the same rationale. (Ross, 1979) Similarly, and currently, in various countries, many early childhood education programs focus on "disadvantaged children." Currently, for example, Sure Start (United Kingdom), Early Childhood Development (ECD) centers (South Africa), and the Early Childhood Development Project (India)—major national programs—have had a major focus on "disadvantaged children." Despite each program's historicity, a similar rationale emerges: early intervention is aimed at improving children's health to make a difference.

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