COMPENDIUM OF CASE STUDIES

Partnerships for the health and well-being of our young and future generations

WORKING TOGETHER FOR BETTER HEALTH AND WELL-BEING
Promoting Intersectoral and Interagency Action for Health and Well-being in the WHO European Region

High-level Conference

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Executive summary

Acting on the root causes of poor health and well-being in childhood and adolescence can improve health across the life-course. Many of the most pressing health problems cannot be solved without addressing the underlying social determinants of health and engaging sectors beyond health. Numerous social, economic, environmental, political, cultural and commercial determinants affect the health and well-being of young people, both in childhood and in later life, and that of future generations, and many influence children’s social, emotional and cognitive development more broadly. Intersectoral action for health and well-being, in accordance with Health 2020, the European policy and strategy framework for health and well-being across the WHO European Region, is therefore critical for addressing the determinants of health of children and adolescents. Health inequalities among children exist throughout the European Region, both within and between countries. Intersectoral action for health can help to alleviate inequalities by ensuring that all vulnerable children gain the most from policies and interventions.

This compendium of case studies and case stories has been compiled to demonstrate examples of cooperation between (1) the health and education sectors and (2) the health and social sectors within the WHO European Region. This is the first edition of a compendium of case studies and case stories compiled for the High-level conference on promoting intersectoral and interagency action for health and well-being in the WHO European Region: working together for better health and well-being, in Paris, France, held on 7–8 December 2016.
Introduction

Many countries are transforming how they improve children’s health and well-being by focusing on tackling health inequalities among children. The adoption of the United Nations 2030 Agenda for Sustainable Development by all Member States in September 2015 has created a unique policy opportunity and agenda that are fully aligned with Health 2020. The Agenda calls for transformative approaches to achieve the 17 Sustainable Development Goals, making innovative and transformative examples especially valuable to this compendium. Cases from countries or regions that focus on the life-course approach and provide specific examples of the process of achieving effective intersectoral collaboration, including challenges and barriers faced during the process, were considered especially valuable for supporting countries in their future implementation of intersectoral approaches. The European Region is diverse, and countries have different starting-points for implementing intersectoral action in their governance structures, cultural constructs, economic and social situations and geographical settings.

Together, this collection of case studies and case stories illustrates instances in which working together across sectors enabled complex health problems to be solved. It demonstrates examples of successful cooperation both between the health and education sectors and between the health and social sectors across the WHO European Region. Collaboration between the health, education and social sectors is critical for promoting health and well-being across the life-course, with the potential to improve health and halt the perpetuation of health inequalities. In accordance with the 2030 Agenda for Sustainable Development, intersectoral action for health, both within and between generations, is critical for sustainable development and for establishing healthy behaviour and sustainable lifestyles.

The purpose of the compendium is to serve as a tool to support countries in implementing appropriate intersectoral policies and interventions to improve the health and well-being of children and adolescents and mitigate health inequalities among children. The case studies and stories can help to facilitate intersectoral action for health across countries by offering examples of and experiences in how to craft and implement intersectoral initiatives and programming. The compendium is intended for use across agencies and sectors, including ministries, government stakeholders and public policy-makers interested in approaches to intersectoral collaboration, to improve the health and well-being of children and adolescents within their respective communities.
Methods

In compiling the compendium, the method used was both responsive to the time constraints of the conference process and ensured that the case studies remained relevant to the conference and its topics. The compilation of the compendium continued an intersectoral mapping exercise that was undertaken by the Division of Policy and Governance for Health and Well-being during 2015–2016 that systematically collected case studies and stories from 36 countries in the Region. The process undertaken to compile the compendium builds on the methods of the intersectoral mapping exercise and its results, which will be published in a forthcoming final report.

Through a literature search of published WHO sources, relevant documents were identified and existing case studies lifted. WHO country offices and other United Nations partners involved in the Conference were engaged and requested to submit examples of relevant case studies. Case studies from 2012 or later were identified, since this was the year that the 53 Member States of the European Region adopted Health 2020. Once collected, the case studies were then organized into two overall themes: collaboration predominantly between the health and education sectors and collaboration predominantly between the health and social sectors. They were then organized into several subthemes under these categories and arranged alphabetically, to facilitate easy access and usability.

The following rules have been applied to the compendium.

- Case studies have been sorted into two categories:
  - predominantly cooperation with the education sector and
  - predominantly cooperation with the social sector.
- Case studies have been organized by subtheme within the two categories.
- Case studies have been arranged alphabetically by country.
Cooperation with the education sector

Subtheme: the built environment

1  Finland – School health check-ups

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

Every year in Finland, parents are involved in three comprehensive school health check-ups at their children’s schools, where they are able to raise concerns about the health and safety of the school setting. This provides an opportunity for the school to engage with the parents, and for parents, as stakeholders, to submit input on the design of the school setting, from physical environment to school catering. This raises awareness of the importance of a healthy setting among parents and ensures that the school is held directly accountable to key stakeholders.

2  Greece and Bulgaria – Healthy Schools Women in Europe for a Common Future pilot project in Greece and Bulgaria

Source: material from the European Agency for Safety & Health at Work (EU-OSHA) relating to partnership action between the International Labour Organization and the WHO Regional Office for Europe.

This case study focuses on the Healthy Schools Women in Europe for a Common Future (WECF) pilot project run by the WECF from September 2007 to February 2010 and funded by a European Commission (DG Environment) Programme and a partnership with organizations in Greece and Bulgaria. The WECF partner organizations were the Earth Forever Foundation (Bulgaria) and Clean up Greece (Greece). The project mainly addressed four public and private educational entities in Greece and Bulgaria, with high transferability potential to other countries as well. The project addressed schools, teachers and, particularly, students, children and their families and offered them the opportunity to learn about their environment and possible ways to improve and protect it by developing their own ideas. Health and safety at school addressed both students and staff, especially through the Fryganiotis Private School (Salonica) approach. This case study deals with the above pilot project developments for two primary and secondary general schools in Greece. Health-promoting schools also aim to promote a safe social environment or climate in schools. This in turn facilitates learning by students and better social lives for both teachers and students by being more open to problems, establishing more trust between teachers and students, and reducing antisocial behaviour.
3 United Kingdom: Northern Ireland – Teaching resource for child-friendly environments


Building a relationship with the education sector at the municipal level has been a key goal and challenge for Belfast Healthy Cities. Traditionally, it has been very difficult for Belfast Healthy Cities and the health sector at the municipal level to effectively engage with them.

Teachers, however, did recognize the value for the education sector in creating child-friendly places and environments. Belfast Healthy Cities therefore created a teaching resource. Although the education sector could not normally identify a direct benefit for schools for collaboration with the health sector, in this instance the health sector was able to effectively identify and communicate the co-benefits.

The resource involved teachers and children preparing proposals to make their local environments (immediately surrounding the school setting) healthier for children – healthy urban environments. One example was redeveloping derelict lots into green spaces with which people could interact.

One small win was managing to get commitment from the local council to buy into the project by showing that involving children in designing and developing the project would not lead to requests that were impossible to fulfil – a concern of the local council. One issue in a particular area was overflowing litter bins. When asked, children asked for more bins to be placed in the area so that the litter would not overflow. The council responded and is committed to considering requests of this kind in the future. In one area the children’s request has been fulfilled already.

Plans are underway to develop children’s proposals further with key stakeholders in the city. Work is also underway to scale the project up from the municipal level in Belfast to the regional level throughout Northern Ireland. There is also a European element to the project, with schools from a number of cities including Athens, Greece and Pula, Croatia participating in the project. Experiences and learning will be shared through the WHO European Healthy Cities Network.

Plans are underway to scale the project up from the municipal level in Belfast to the regional level throughout Northern Ireland. There is also a European element to the project, with experience being shared between such cities as Athens, Greece and Rijeka, Croatia through the WHO European Healthy Cities Network.

4 United Kingdom – A whole-school approach to a healthy school in the United Kingdom

Source: material from the European Agency for Safety & Health at Work (EU-OSHA) relating to partnership action between the International Labour Organization and the WHO Regional Office for Europe.

In the United Kingdom, the whole-school approach introduced a system to address issues that is more likely to generate long-lasting results. This is based on the premise that, when schools
and parents own and drive changes within the school environment, any improvements arising from these changes become self-sustaining within the schools. Depending on the systems introduced, they are able to maintain high levels of equity and improve standards. The whole-school approach allows the education system to concentrate on the needs of the individual – with educational processes adapted to each child’s needs and allowing parents to have an input in how schools are run.

The whole-school approach focuses on all aspects of the school: the students, the teachers, the parents, the curriculum and what happens during the day when at school, with the following 10 elements:

- leadership, management and managing change
- policy development
- curriculum planning and resources, including working with outside agencies
- learning and teaching
- school culture and environment
- giving children and young people a voice
- provision of support services for children and young people
- staff professional development needs, health and welfare
- partnerships with parents and caregivers and local communities
- assessing, recording and reporting children and young people’s achievement.

The National Healthy Schools’ Programme, within the whole-school approach, provides a model for partnership working between health services, local authorities and schools, with the aim of promoting a coherent and holistic message about the importance of choosing a healthier lifestyle.

The criteria for National Healthy School status include concentrating on four themes:

- personal, social and health education
- healthy eating
- physical activity
- emotional health and well-being.

The whole-school approach develops an ethos and environment that supports and promotes physical and emotional health and well-being. It allows the entire community to work to achieve the National Healthy School status and places children and young people at the heart of learning and teaching. Increased participation in the programme builds collaborative partnerships, supports schools in demonstrating their contribution to the five Each Child Matters outcomes for children and young people and is an effective, evidence-informed school improvement mechanism that brings about and embeds cultural change in schools.
The Effective Provision of Pre-school Education (EPPE) project led by Edward Melhuish has produced major government policy changes since 2008. EPPE is a longitudinal study focusing on how early childhood education and the home learning environment affect educational and social development. The government’s recent decision to extend free early-years provision for disadvantaged children was based on EPPE’s finding (highlighted in several government reviews) that good-quality early education has long-term benefits, especially for disadvantaged children. EPPE also demonstrated the critical role of better-qualified early-years staff, which has led to new policy recommendations on staff training. A parallel project was conducted in Northern Ireland (EPPNI). These projects were conducted jointly by Birkbeck College, the Institute of Education and the University of Oxford.

In EPPE, more than 3000 children were followed from age 3 years, with retrospective data going back to birth. Their development was monitored until they entered school (age 5 years) and then at key time points (6, 7, 10, 11, 14 and 16 years).

Observations, interviews, questionnaires and assessments were conducted longitudinally alongside national data on primary and secondary schools, focusing on factors and experiences related to children’s cognitive, educational and social development, and intensive case studies to ‘un-pack’ effective practices.

EPPE showed that preschool education enhances all-round development in children, with every month after 2 years of age adding benefit. Disadvantaged children benefit significantly from good quality pre-schooling, especially in integrated settings and nursery schools. Staff members with higher qualifications offer richer learning environments, with sustained beneficial effects on development. Longer-term effects showed at stages 2 and 3 (ages 11 and 14 years), and good early-years experiences confer significant lasting benefits in terms of better attainment and social and behavioural outcomes.

In summary, high-quality preschool education acted as a protective factor for children who went on to attend a less effective primary school. Quality preschooling for the most disadvantaged children can prevent special educational needs later. Moreover, preschool and primary school have combined effects in shaping children’s educational outcomes, especially for disadvantaged children. Other EPPE findings highlight the importance of the home learning environment, especially for vulnerable groups.
6 United Kingdom: Scotland – Consulting with young people in Scotland


In 2010, Scotland’s Commissioner for Children and Young People conducted a national consultation involving 74 059 Scottish children and young people. Children and young people repeatedly raised the issue of safe school toilets when the Commissioner visited schools, youth clubs and care settings.

In a survey conducted under the same project, 2154 young people in 59 secondary schools were asked what they thought about their school toilets. The following key findings were drawn.

- Only four in 10 students say they use school toilets whenever they need to (41%).
- Of the students who have to seek permission to go to the toilet, 18% are rarely or never allowed to go.
- Many students feel uncomfortable when asking for permission (especially girls).
- Almost one third of students rate the school toilets as poor or very poor, and most students report issues concerning locks, provision of hygiene consumables and overall cleanliness.

About 100 students, staff and parents joined an expert working group to help and inform about the areas to give priority in a guidance document aimed at improving school toilet provision and outlining a management strategy that caters for all children and young people in schools. The guidance is expected to be issued to all Scotland’s local authority education departments by the end of 2016. The expert group comprises members of the Scottish Government, Scottish Youth Parliament and nongovernmental organizations, with continuing involvement from children and young people and Scotland’s Commissioner for Children and Young People. The guidance aims to improve the standards and qualities of school toilets in Scotland.

Subtheme: child abuse and bullying

7 Cyprus – A National Strategy and Action Plan to Fight Sexual Abuse, Exploitation of Children and Child Pornography


Child sexual abuse is a problem worldwide that persists in the WHO European Region. Analysis of community surveys from Europe and around the world has estimated a prevalence rate for sexual abuse of 10% (13% for girls and 6% for boys). Child sexual abuse, exploitation and child pornography is also an issue of concern to Cyprus. In 2015, the Council of Ministers decided to tackle this issue by establishing an Ad Hoc Ministerial Committee with the Ministers for Labour, Education, Health and Justice to coordinate the preparation of a

The goal of the Strategy is to protect children in Cyprus from all forms of sexual abuse and exploitation and pornography. This initiative received high-level political commitment and was triggered by the need to enforce existing legislation (2014) based on the Council of Europe Convention on Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention). Intersectoral action was chosen to ensure coordination in addressing cases and applying a coherent, systematic approach to dealing with the issue. The media broke the silence and raised awareness among the public. This, coupled with the introduction of the new law supported by the ongoing ONE in FIVE campaign, provided momentum for action.

The Ministry of Labour took the lead since social issues fall under its mandate. The Ministry of Health provided technical expertise and assumed an advisory role, providing the scientific evidence. Within the context of developing the Strategy, the Ministry of Justice and Public Order ensured that a specialized police group will be educated on how to obtain video-recorded statements to investigate sexual violence offences against children according to location (rural or urban). Within the context of developing the Strategy, the Ministry of Education offered seminars in schools for teachers on sex education, preventing sexual abuse, diversity in school, anti-racist policies and actions, the sexual and reproductive health of adolescents and other topics. Nongovernmental organizations (NGOs) pressured the government to act on this issue, prepared the action plan of the Strategy and providing funding. The private sector, psychologists and social workers, offered their specialized services. The media ensured wide coverage of the issue throughout.

Information sharing came naturally by enforcing existing legislation. Parliament encouraged sectors to work towards a single strategic plan. Parliamentary hearings facilitated the process. Bureaucracy-free working and open communication facilitated the intersectoral working group’s job.

The main financial leader of the initiative is the government of Cyprus. Hope for Children (an NGO) provided €300 000 for the project and a house for the victims. This programme has led to better links and collaboration being established with other sectors.

An intersectoral working group with accountability for the plan and open communication was key to success. Initial resistance to intersectoral working and thinking out of the box was overcome once work began. Small country size and proximity made for easy dissemination. Existing legislation meant that a legal framework was available to build on, with international commitments supporting this. Support from NGOs and private practitioners by means of funding and time were also key enablers.

The health of all children in Cyprus and future mental well-being, as a human right, is the foundation for this plan and its strategic goals. Wide sector involvement, including a strong NGO presence and media pressure, helped develop the best plan for benefiting children. Cyprus has recorded significant achievements in fighting sexual abuse and sexual exploitation of children in recent years as a result of this well coordinated effort.

The Ministerial Council approved the National Strategy and Action Plan in March 2016.
8 Finland – Prevention, intervention and monitoring


KiVa is a research-based antibullying programme that has been developed at the University of Turku, Finland with funding from the Ministry of Education and Culture. The effectiveness of KiVa has been shown in a large randomized controlled trial. In Finland, KiVa is a sought-after programme: 90% of all public secondary schools in the country are registered KiVa schools implementing the programme.

KiVa is an evidence-informed programme to prevent bullying and to tackle the cases of bullying effectively. The former is crucial but also the latter, since no prevention efforts will make bullying disappear once and for all; there need to be tools available when a case of bullying comes to light. The third aspect of KiVa is continual monitoring of the situation in one’s school and the changes taking place over time; this is enabled by the online tools included in KiVa. These tools produce annual feedback for each school about their implementation of the programme as well as the outcomes obtained.

Main components of KiVa

KiVa includes both universal and indicated actions. The universal actions, such as the KiVa curriculum (student lessons and online games), target all students and focus mainly on preventing bullying. The indicated actions are to be used when a bullying case has emerged. They are targeted specifically to the children and adolescents who have been involved in bullying as perpetrators or victims and to several classmates who are challenged to support the victim; the aim is to end bullying.

KiVa is a school-wide approach to decreasing the incidence and negative effects of bullying on student well-being at school. The programme’s impact is measured through self- and peer-rated reports of bullying, victimization, defending victims, feeling empathy towards victims, bystanders reinforcing bullying behaviour, anxiety, self-esteem, depression, liking school and academic motivation and performance, among other factors. The programme is based on the idea that how peer bystanders behave when witnessing bullying plays a critical role in perpetuating or ending the incident. As a result, the intervention is designed to modify peer attitudes, perceptions and understanding of bullying. The programme specifically encourages students to support victimized peers rather than embolden bullying behaviour and, further, provides teachers and parents with information about how to prevent and address the incidence of bullying.
9 Kyrgyzstan – Protocol on cross-sectoral cooperation


The special protocol on cross-sectoral cooperation to protect learners from violence in general educational settings in Kyrgyzstan provides a framework for violence prevention and response in educational settings and referral mechanism to health, social and other community-based services. It was developed for the School without Violence project implemented by the Child’s Right Defenders League and supported by the Ministry of Education. More information about the project is available at: http://crdl.kg/ru/schools_without_violence.

10 Ireland – Anti-bullying procedures for primary and post-primary schools


The purpose of these procedures is to give direction and guidance to school authorities and school personnel in preventing and tackling school-based bullying behaviour among students and in dealing with any negative impact within the school of bullying behaviour that occurs elsewhere.

11 Republic of Moldova – National policy to prevent violence against children and their exploitation, neglect and trafficking


This national policy sets a framework for cooperation across several sectors (social, education, health, domestic affairs and other) to prevent violence against children, their exploitation, neglect and trafficking.

According to the Decree, all educational institutions, health-care facilities, social services and other community-based authorities and institutions, including NGOs, must register and keep record of all cases of child abuse, neglect, violence and trafficking, and they must immediately respond and inform local guardianship bodies, police, emergency health care and other relevant services about such cases. The Decree provides a protocol for appropriate response, case management and follow-up for every case of child abuse, neglect, violence or trafficking.
12 Regional – Olweus Bullying Prevention Program


Dan Olweus of Norway developed the Olweus Bullying Prevention Program. The Program has more than 35 years of research behind it and has been implemented throughout the world, in countries such as Canada, Croatia, England, Iceland, Germany, Mexico, Sweden and the United States, in addition to Norway. The Program is a comprehensive model that uses annual surveys, classroom curriculum, implementation resources and training. When the Program is implemented as written (in accordance with the Program components and principles), positive outcomes for schools include: reductions in bullying behaviour, lower rates of alcohol and other drug abuse; and improved academic achievement. Implementation should include the guidance and expertise of a certified Olweus trainer.

13 Regional – Violence prevention in educational settings


The guide for educators on violence prevention in educational settings for eastern Europe and central Asia examines various types of school violence with particular attention to gender-based violence. It looks at the causes and risk factors of violence, different actors, their roles and key characteristics, gender and age differences. Along with an overview of the scale and character of school violence in several eastern European and central Asian countries, the guide presents national policy frameworks and examines existing practices in addressing violence and how it affects individuals and the whole school. The guide comprises a set of examples and tools for school assessment and creating a positive climate and a safe and enabling learning environment; community engagement and cooperation with health-care and social services, police, local administration and NGOs to implement violence prevention measures and offer training, support and referrals to learners, teachers and parents.

14 Regional – Practical recommendations on implementing HIV policy in the education sector in eastern Europe and central Asia


The practical recommendations provide a framework for countries in eastern Europe and central Asia to review and improve national policies and the policies of individual education institutions at all levels of education to ensure a discrimination-free, safe and supportive learning environment and to uphold the rights of all workers and learners, including those living with or affected by HIV. The practical recommendations promote cooperation across the education, social and health sectors to ensure high-quality education, care and support to people living with or affected by HIV.
The practical recommendations informed the development of national HIV policies for education sector in:

- Belarus (http://www.academy.edu.by/component/content/article/45/445-2012-07-20-11-37-47.html);
- Kyrgyzstan (http://www.unesco.kz/hivaids/2013/Recommendation%20on%20HIV%20Policy_KG_ru.pdf);
- Russian Federation (http://cipv.ru/images/all1/pdf_2012/HIV_Russia_2013.pdf);
- Tajikistan (http://www.unesco.kz/new/ru/unesco/news/280); and

15 Global, including country-specific examples – Education sector responses to homophobic bullying

Source: UNESCO. 2012. Education sector responses to homophobic bullying. (http://unesdoc.unesco.org/images/0021/002164/216493e.pdf; in English and also available in French, Italian, Polish, Portuguese, Russian and Spanish).

Characteristics of effective school antibullying policies and programmes

- Start when children are still young before their attitudes and behaviour become fixed.
- Ensure that the antibullying policy covers everyone in the school community.
- Involve all key stakeholders – school principals, staff, learners, parents and the wider community – in developing, implementing and monitoring the effectiveness of school antibullying policies.
- Develop a comprehensive prevention strategy that includes staff training and using appropriate outside expertise.
- Ensure that the policy includes a clear action plan to make the victim safe and provide support, decide on sanctions and rehabilitate offenders.
- Put in place systems for learners and staff to report bullying, for example, confidential complaint systems, using school or community child protection officers.
- Ensure that all school staff members take action to prevent bullying and address any form of bullying in a consistent and systematic way. Make the antibullying policy visible, including in the staff handbook, school prospectus and at open days and parents’ evenings.
- Monitor student behaviour, especially when there is evidence that bullying may be taking place.

Characteristics of schools with an effective diversity policy

- The school sets clear rules on how to behave right at the beginning of the school year and all staff enforce the rules.
- The school organizes mutual social support among teaching staff and learners.
The school cultivates an open attitude.
- The school offers explicit information about gender, diversity and discrimination.
- There is a procedure, open to everybody, for handling complaints and preferably an independent committee to adjudicate the complaints.
- There is a school counsellor who knows how to support learners and staff who have complaints about discrimination and other negative behaviour.
- Learners and teacher initiatives to combat discrimination and to improve the school climate are welcomed.

Four essential dimensions of school climate

1. Safety
   - Rules and norms
   - Physical safety
   - Social and emotional security

2. Teaching and learning
   - Support for learning
   - Social and civic learning

3. Interpersonal relationships
   - Respect for diversity
   - Social support – adults
   - Social support – students

4. Institutional environment
   - School connectedness and engagement
   - Physical surroundings

In Ireland, for example, the findings of a comprehensive national survey on suicide among adolescents led education ministry action to address homophobic bullying in schools and including young gay, lesbian, bisexual and transgender people as a key population in the National Suicide Prevention Strategy. Schools are governed by the Education Act 2000 and the Equal Status Act 2000–2008 and “have a responsibility to address homophobic bullying and respect for difference and diversity when addressing bullying”.

In the United Kingdom, for example, civil society organizations such as Stonewall have worked closely with the Department for Education to integrate opposition to anti-homophobic bullying within existing Safe School Policy frameworks. Schools are now legally obliged to address homophobic bullying. The government has made tackling this issue a priority. The Anti-Bullying Team of the Department for Education has worked with Stonewall to draft antibullying advice for schools, and the official school inspection body now includes
consideration of homophobic bullying and safety of lesbian, gay, bisexual and transsexual learners in inspections.

In the Netherlands, with the support of the Ministry of Education, Culture and Science, the organization COC Netherlands is working to create awareness of homophobia among school boards and to encourage boards to make schools a safer environment. COC Netherlands developed a booklet of stories about young people’s experiences of being lesbian, gay, bisexual and transgender in school, which resulted in a number of schools signing a memorandum of understanding in which they committed to take responsibility to combat homophobia.

LGBT Scotland has developed a toolkit on partnerships between education ministries and NGOs to tackle homophobia in schools. It is also implementing the Challenging Homophobia Together project in Scotland, which aims to reduce homophobia and homophobic bullying in schools through workshops and interactive lessons with learners, training and a toolkit for teachers, support to develop school policies that are consistent with current legislation and best practice and support for learners who need information or advice.

16 Global and regional data, including country-specific examples – Out in the open: education sector responses to violence based on sexual orientation and gender identity and expression


In the European Region, some countries have specific laws and policies to address homophobic and transphobic violence in educational settings. In Belgium, the Flemish ministry for Education and Equal Opportunities issued a Common Declaration for a Gender-Sensitive and LGBT Friendly Policy in Schools in 2012, establishing a framework for sexuality education and providing guidelines for schools to develop LGBT-inclusive policies. In France, although no national policy mentions homophobic and transphobic violence, the Ministry of Education’s annual letter to principals has mentioned combating homophobia since 2009. Further, a 2012 government plan to combat homophobic and transphobic violence foresees specific actions in the education sector. In Sweden, the Discrimination Act (2009) explicitly bans discrimination on the basis of sexual orientation and gender identity or expression in education and obligates preschools, schools and universities to take proactive measures against violence. The United Kingdom’s Equality Act (2010) obligates schools to advance equality for their LGBT students. The Act explicitly mentions sexual orientation and gender reassignment and mandates that every school have a behaviour policy preventing all forms of bullying.

Malta: groundbreaking legislation and policy on gender identity and expression and intersex status

In Malta, the Gender Identity, Gender Expression and Sex Characteristics Act (2015) was adopted in April 2015. It outlaws a range of discriminations based on an individual’s gender identity and expression or sex characteristics. To help the education sector adapt to this new law, the Ministry for Education and Employment published the Trans, Gender Variant and
Intersex Students in Schools Policy in June 2015. This allows students to: present themselves and be addressed according to their preferred gender identity or expression; choose the facilities, such as restroom, that match their gender identity or expression; and wear a uniform that matches their gender identity or expression. The policy also includes recommendations for implementation in schools.

Ireland: developing a comprehensive response to homophobic and transphobic violence in educational settings

In 2013, Ireland adopted a new comprehensive national plan to address bullying in schools, including homophobic and transphobic bullying. Key steps in the process included the following.

2005: producing evidence. Through research, BeLonGTo, a youth NGO, identified a link between coming out and self-harm for LGBT children and young people. This led to the group being recognized as a key population in the National Suicide Prevention Strategy.

2009–2011: widening the evidence base. Two additional pieces of research, commissioned by NGOs, generated evidence about the mental health of LGBT people and the lives of older LGBT people, starting a national conversation about daily realities for the LGBT community.

2010: pledging action. Teachers’ unions and LGBT and youth NGOs presented the evidence to political and education sector leaders ahead of a national election, asking for action. The political parties forming a government committed to developing antibullying policies (including addressing homophobic bullying) in their programme.

2012: getting to work. The Department of Education and Skills organized the first public antibullying forum and started an antibullying working group, which included policy-makers, experts and NGOs.

2013: a new policy. The Ministers for Education and Skills and for Children and Youth Affairs jointly launched the National Action Plan on Bullying, which referred to homophobic and transphobic bullying. The plan included financial support for information campaigns, LGBT-sensitive school inspections and training teachers on sexual orientation and gender identity and expression issues. It also included incorporating homophobic and transphobic bullying into new mandatory antibullying procedures for all schools.

2015: guidelines for implementation. The government issued national antibullying procedures to help primary and post-primary schools to implement the National Action Plan on Bullying.
Subtheme: mental health

17 Norway – A solution-focused approach to improve self-esteem among socially withdrawn schoolchildren


Young people’s social skills and health can be improved by increasing self-esteem. Self-esteem helps young people to believe in themselves, become more self-confident, improve their ability to stand up for themselves and reach their goals in school. Socially withdrawn children were reported to have less success in achieving assertive goals. The role of the school nurse is important in health promotion, using practices that are supportive and promote healthy decision-making. This intervention study was based on a solution-focused approach group that was delivered by school nurses to improve self-esteem among socially withdrawn schoolchildren. The solution-focused approach highlights the children’s personal strengths and successes as valuable learning experiences rather than dealing with their experience of deficits and failures.

In this study, the school nurses received training in the solution-focused approach and subsequently led all group meetings. The school nurses enhanced their role by supporting vulnerable children in elementary school to believe in their abilities in addition to learning new skills on how to use solution-focused approach in groups. The school nurses received regular support from professional supervisors.

The results from this study indicate that the self-esteem of socially withdrawn children 12–13 years old improved using a school-based intervention with a solution-focused approach. Compared with the control group, the self-esteem scores among the girls in the experimental group increased significantly at the first post-intervention evaluation. Self-esteem scores increased from the baseline to the second post-intervention evaluation in both the experimental and the control group but increased more among the children of the experimental group.

This study demonstrates that socially withdrawn children can benefit from a group solution-focused approach intervention to develop social competence and skills and reach their goals. Participating in a group assists in learning from other participants, sharing feelings, experiences and gaining and providing support. These results indicated that the solution-focused approach is suitable for school nurses in their work with children with special needs.

Collaborative interprofessional relationships were fostered between the school nurses, teachers and professors. School nurses reported improved job satisfaction and improved communication with school staff, and the overall environment among the group members also improved.
Subtheme: environmental education

18 Greece – Environmental and health curriculum

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

Since 1995, Greece has maintained a focus on environmental education throughout its national curriculum. A network of 53 centres for environmental education has been running, which encourage close collaboration between the Ministry of Health, the Ministry of Education, Research and Religious Affairs and the Ministry of Environment and Energy. The centres for environmental education run several thematic networks at the school level, focusing on different topics of environmental education.

Although finances limit the programme, the collaboration between the health, education and environmental sectors is longstanding and provides a solid foundation to integrate environmental education for sustainable development, and the health effects, into the national curriculum in Greece.

Subtheme: extended services: family and parenting support and interaction with the community

19 Belgium, Netherlands and United Kingdom – School-based examples for community activities and services


The school-based examples lead to a rethinking of schools’ roles. The primary purpose is education, but some countries, including Belgium, the Netherlands and the United Kingdom, are looking to models of full-service or extended schools as a base for a wide range of community activities and services.

20 Cyprus, Denmark and France – School-based programmes for children and young people at risk of vulnerability


Cyprus, Denmark and France also provide good case studies of school-based programmes that focus on groups of children and young people who are particularly vulnerable to poor outcomes. Schools tend to reflect the social environment in which they are located, so those in
disadvantaged areas can provide excellent settings for ensuring disadvantaged groups receive extra support. The danger of this approach is that many disadvantaged children do not live in poor areas or attend school there.

21 **Georgia – Educational elements in childcare centres**

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

Georgia has implemented a joint programme between sections of the Ministry of Labour, Health and Social Affairs that brings educational elements to childcare centres. The programme targets mainly children from poor families and focuses on three directions: elementary life skills, literacy and mathematics. Although one side of the programme offers services to, and educates, the families, another side educates health, social, and education sector workers on how to deal with the type of children seen in the programme. The programme also includes child behaviour specialists offering psychological services and assistance to children and families.

The programme’s functioning is defined by regulatory frameworks and the financing and budgeting mechanism linked to them. Different regulatory frameworks exist in different contexts and must be considered when drafting region-wide recommendations for improving intersectoral collaboration between sectors.

22 **Ireland – Social, personal and health education programme**


Ireland is working to strengthen the links between the schools and the community. The 1998 Education Act states that Ireland should provide a moral, spiritual, social and personal education for all. A national programme for education and support for socially disadvantaged children exists. It focuses on the children who are at risk of leaving school early, and through early intervention, aims to prevent this scenario.

A social, personal and health education programme, at both the primary and secondary levels, also aims at teaching children skills with which they can become active, critical thinking citizens. The programme reiterates this by making strong links to the community settings, ensuring that children feel a part of the local community. The programme forms part of a well established partnership between the Ministry of Health and the Ministry of Education. From September 2017, student well-being will be more strongly emphasized, with a focus on enhancing the physical, mental, emotional and social well-being of students. Although certain core elements of the programme will remain compulsory, such as physical education and personal, social and health education, schools will be given freedom in shaping the rest of the programme to ensure context-specific programmes.
23 Netherlands – Universal parenting support


Different categories of parenting and family support services can be distinguished: those that are either targeted or universal, are standardized through a manual or fixed set of activities or are more informal, relying on practitioner judgement. Baby and toddler health centres in the Netherlands provide an example of universal parenting support. Many municipalities in the country have been involved in restructuring services and have launched family-support systems such as a front-desk post for youth health care, culminating in centres for youth and family that include the baby and toddler health-care centres.

24 Russian Federation – Parental involvement in health promotion


In 2010, the Russian NGO Humanitarian Project launched a special programme called 15 that involves parents in prevention activities. The programme comprises 15 three-hour thematic sessions for adolescents and their parents or guardians. Participants are divided into four age- and sex-based groups, and each group participates in specific training sessions. In addition to the group work, joint sessions are organized with all four groups to discuss various topics. Training sessions and joint discussions aim to improve parent–child relations and strengthen participants’ knowledge about substance use, HIV and other sexually transmitted infections. The programme helps adolescents to understand themselves, find solutions for difficult situations, build trust-based relationships with family members, develop plans, set goals and achieve them and be more confident. Parents have the opportunity to discuss child-rearing problems, share experiences, get to know their children better and master effective communication skills. The training sessions help them to learn more about HIV, drug use, reproductive health and the sexual behaviour of adolescents, so that they are able to discuss these issues with their children without being overbearing or moralizing. According to the programme evaluation survey held in eight regions of the Russian Federation, more than 90% of participants noted that 15 had brought positive changes to their lives. Some 55% of respondents had improved their relationships; 50% had started planning for the future; 32% had abstained from risky behaviour; and 10% had been tested for HIV. Among adolescents who participated in the programme, the share of smokers decreased from 27% to 3%, and all respondents who had consumed alcohol previously reported that they had been abstaining from it. Similar results were achieved among the parents: the proportion of smokers fell from 50% to 30% and the proportion of alcohol users fell from 17% to 3%.
25 United Kingdom: England – Schools offering extended services


By 2010, every state school was expected to offer access to a range of extended services, including out-of-hours activities, learning and childcare, family support, adult education, community access to school facilities and close partnership with specialist services such as health care and social care. They are sometimes offered on an open-access basis but often target children and adults at higher risk, with schools serving deprived communities commonly offering the richest array of services.

Typically, groups of schools work together to offer services in partnership with other community groups and agencies. Although schools have considerable flexibility in deciding what is needed in their areas, their decisions form part of local strategies for providing services and tackling disadvantage. These in turn have been part of a set of national strategies for promoting children’s well-being and reducing social exclusion.

In practice, schools address a wide range of issues through their services. Improving educational attainment overall and/or narrowing the attainment gap between their lowest-performing students and the rest are important issues for them, but they also tackle children’s personal and family difficulties, including specific health issues such as teenage pregnancy or obesity. Schools very often see extended services as closely related to their efforts to become a health-promoting school, but some also use their services to increase the life chances of people living locally, tackle interethnic tensions in local communities or contribute to economic regeneration in areas they serve.

These initiatives have been extensively evaluated, with positive findings. Significant effects on educational and other outcomes (including health outcomes) for children and adults at greatest risk have been seen, but the evidence for effects on overall levels of attainment is less convincing, as is that on whether schools can make a real long-term difference to the areas they serve.

26 United Kingdom: Scotland – Curriculum for Excellence Scotland


The Scottish Government has decided to reduce inequalities in Scottish society. One of the aims of the National Improvement Framework is to improve children’s and young people’s health and well-being. Within this context, a major curriculum reform was introduced and has been implemented since 2010–2011. The Curriculum for Excellence in Scotland is designed to achieve a transformation in education in Scotland by providing a coherent, more flexible and enriched curriculum from 3 to 18 years old. The curriculum includes the totality of experiences planned for children and young people through their education, wherever they are
being educated. The curriculum focuses on the needs of the child and is designed to enable them to develop the following capacity: successful learner, confident individual, effective contributor and responsible citizen. The Curriculum for Excellence offers better educational outcomes for all young people. It focuses on literacy, numeracy and health and well-being at every stage. Learning in, through and about health and well-being promotes confidence, independent thinking and positive attitudes and dispositions.

27 United Kingdom: Wales – Swansea, Wales: using the strength of the local Healthy Schools scheme to promote the benefits of immunization to children and their families


Schools have become locations for the delivery of immunization programmes as well as health education. Healthy School teams coordinate delivery of the programme locally, provide advice and support to schools and facilitate access to training and materials. Evidence indicates that health-promoting schools have more effective liaison between home and school. There are several immunization programmes running in schools, and by 2013/2014 we still had not reached the targets in any of them. To standardize and coordinate the approach, one of the Healthy Schools coordinators led on immunization across the Health Board area. She focused on improving the nasal influenza uptake in year 7 in 2014/2015.

The approach with the school nursing service included: inclusion within Healthy Schools newsletters; encouraging schools to share messages via their social media platforms and other communication mechanisms; training for teachers; disseminating resources; school nurses delivering assemblies to year 7 to encourage informed consent; and the school health nurses actively following up the nonrespondents.

The strategic and operational achievement was the influenza uptake in year 7 increasing by 7.7% from 2014 and exceeding the immunization target of 75%. Critical success factors include the established relationship of the local scheme with schools and the school nursing service to help to communicate information about immunization programmes. Challenges include not being able to attribute the change solely to our joint work, but there was not any other promotion to this age group. The lessons learned include: having one lead Healthy Schools coordinator linking with the others was successful in disseminating clear, consistent and accurate messages; using the school social media opportunities with other immunization programmes; and the need to encourage co-production with children in delivering the messages. A standardized and coordinated approach using a combination of methods seems to have been effective in improving influenza uptake among schoolchildren 11–12 years old.
Subtheme: general health promotion

28 Cyprus – Innovative funding for health promotion


The Health Education Office sends a circular each year to the directors of elementary, secondary and technical schools inviting applications for funding to support health promotion programmes, encouraging involvement of a wide range of approaches rather than simply traditional forms of health education.

Schools are expected to embed their proposals within their action plans on health education, involve community groups and organizations and bring about sustainable changes to the school environment, children, teaching staff or community.

Funding is available only for schools in zones of educational priority (that is, those serving disadvantaged populations) or for projects targeting high-risk groups. Although funding is for health promotion, any activities that address social determinants of health are considered.

Some projects, for instance, fund activities outside normal school hours for children living in deprived areas or who display difficult behaviour or are otherwise at risk. These are intended to give children a safe place and to promote their personal development. Activities with parents have also been supported, with parents playing a role in deciding the activities they would like to be able to access.

29 France – Learning to Live Better Together


Learning to Live Better Together, a school health promotion programme focusing on social climate, was implemented in 115 primary schools across six regions. The aim was to develop sustainable health promotion projects in the school setting through empowering local actors, employing a comprehensive approach that covered teaching, social and physical environment and links with families and community.

Students were stratified into four different privilege categories in the evaluation, and the programme reduced inequity among students in relation to specific outcomes. The overall conclusion was that schools can contribute to reducing the health divide but should not be considered the magic bullet. Empowering actors and building stronger links among schools, families and local communities are therefore important elements in reducing the gradient of health inequities.
The programme recommended that the following dimensions be in place to ensure the approach’s effectiveness:

- a comprehensive approach
- an approach deeply rooted in the educational culture of the country or region
- empowerment of a wide group of local actors
- a sustainable long-term policy.

### 30 France – Health pathway programme

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

Article 6 of France’s Education Law, adopted in 2013, states that “health promotion activities” fall under the missions of education. The “health pathway” programme in the curriculum is enshrined in the law and insists that intervention be made at the earliest age possible and until the very end of the school curriculum. The programme advocates intervention: starting as early as possible, in kindergarten, at a time when children begin to develop knowledge and skills, and which will decline until the end of the curriculum and schooling; ensuring and improving students’ well-being at school; participating in the fight against social inequalities in health; and creating a structuring and fulfilling environment.

The health curriculum needs to be included in all school projects and developed in three main areas: health education, disease prevention and health protection. It reflects a specific educational approach that promotes the acquisition of skills, knowledge and behaviour.

The health curriculum should involve not only educational professionals but also health professionals, social workers and, more and more, parents. Health and citizenship committees have thus been created within each school to identify the needs and determine the action needed. A collective and interdisciplinary reflection with all relevant actors and staff members is necessary to ensure coherence. Parents are also involved in the programme in various ways, either being consulted in the structure, informed of the development or sometimes directly involved in the programme, either as a deliverer of knowledge or a recipient.

### 31 Hungary – Comprehensive health promotion at schools


The Act on Health Care adopted in 2011 set the background for comprehensive health promotion at school. The diseases affecting young people, disease prevention and health promotion, awareness-raising among the Hungarian population and the implementation of regular screening programmes among defined age groups were set as high priority. The EMMI (ministerial) decree defined the aim of comprehensive health promotion at school, to ensure that all children participate in the health-promoting activities, which effectively improve physical and mental health and their well-being. The key action points include healthy diet, daily physical education, physical activity, physical and mental health development, preventing behavioural dependence and the consumption of products causing
dependence, prevention of school violence and personal hygiene. The schools in cooperation with the school health service have to develop and implement the local health promotion programme. Adoption of relevant legislation was the first step towards achieving the goals of comprehensive health promotion. To support the implementation of these goals, three projects were launched funded by the European Union. The initiative was triggered by the launch of Healthy Nation – National Public Health Programme in 2001 and further supported by the decisions of the Public Health Interministerial Board in 2003.

School health promotion is seen as an intersectoral responsibility and not only that of the health sector. Comprehensive health promotion is therefore a shared goal between the Department of Health, the Department of Sport and the Department of Education. The support of the Prime Minister is also very important for promoting daily physical education. The organization of the Ministry of Human Capacities, which is responsible for health, education, sport, higher education, youth and family, social integration, culture, church and civil society, provides important intersectoral mechanisms for joint action since it brings often-conflicting government sectors under the same roof. Effective intersectoral coordination was secured by the involvement of all key actors.

A win-win situation has been considered from different angles. For the health sector, it was most important to secure primary prevention of most noncommunicable diseases and better physical and mental health for all children. For the education sector, better health for all children has been seen as a prerequisite for better academic achievements, more effective work of the teachers, less absenteeism and less aggression. For the sports sector, the objective was to support the development of fit and healthy children that would have better chances in junior education and competitive sports. Higher education connected better health with better academic achievement. Social integration has been concerned with children from the most disadvantaged groups, who can easily be reached in the school and have lower socioeconomic and health status. Comprehensive health promotion aims at better health and equal opportunity for all children. Culture has seen art classes at school as a significant factor in promoting children’s mental health.

Several NGOs were involved in the process. Long-term and stable commitment in the health sector from 2001 on was one of the most important facilitating factors. Long-term and persistent civil work from the medical societies, in good cooperation with the NGOs representing the teachers, was another.

Based on the legislation adopted in 2011 and on gradual implementation, all students have had physical education classes every day from the academic year 2015/2016: 5 times 45 minutes of physical education per week.

32 Italy – Health literacy in schools as a city strategy in Udine


The Municipality of Udine in collaboration with local stakeholder and institutions such as the local health agency, schools, the regional government, economic organizations and voluntary associations has proposed a comprehensive health programme. The programme approaches health topics in an integrated and holistic way and is aimed at fostering positive attitudes, self-
responsibility and capability for health and well-being as it relates to increasing awareness in healthy nutrition, dental health, active living, sustainable mobility, alcohol misuse prevention, injury prevention and safety at school and home, smoking prevention, environmental health, relationships and sexuality education, promoting a positive self-concept, information on sexual diseases and gender relationships to facilitate the transition into adolescence (sexuality and mental and physical well-being).

The programme has resulted in reinforcement of the alliance for health intersectorally, which has led to an increase in structured and coordinated projects and to a more effective dialogue with families. The continual reinforcement and support across sectors increases the positive outcomes in joint action on health and education. It is important to involve young people in a health programme in a meaningful way as to guide them in developing healthy lifestyles and to empower them to choose health-enhancing behaviour and to alter the environments that affect them. The introduction of health promotion projects and events in such a stable way within school programmes has been mainly due to a strong political commitment and to the sensitization of school directors and teachers.

33 Latvia – Guaranteeing a healthy start in life


A national intersectoral conference brought together representatives from the health, education and agriculture sectors; regional development authorities; municipalities; producers; and the food industry in Latvia. The aim of the meeting was to revise the collaboration among these sectors in schools, focusing on such areas as school nutrition, physical activity, health education, health literacy, health promotion and adequate school environments. The final report highlighted the importance of vertical coherence for successful implementation at all levels of government. At the end of 2012, the Ministry of Health of Latvia and the Centre for Disease Prevention and Control started collaborating with the Latvian Healthy Cities Network to improve implementation at the municipal level. As a result of this process, the number of hours dedicated to physical activity at schools has been increased and the health and education sectors are working together to improve the health curriculum at schools with a stronger focus on health promotion.

34 Slovenia – Integrating health promotion within the school curricula


Slovenia has high attendance at both primary and secondary schools. The health and education sectors have joined forces to strengthen health promotion activities while
integrating them within the existing school curriculum. This approach avoided creating new modules that would require additional human and financial resources. Mandatory breakfast has been established at primary schools and mandatory lunch during secondary education. Physical activities include compulsory swimming lessons as a measure to reduce the high mortality rate from drowning. Further, the introduction of toxicology lessons at high school aims at raising awareness on product safety.

35 United Kingdom: England – Enhancing the life chances of children and adolescents: school nursing services to support local population needs


Recognizing the importance of school nursing in the public health strategy Healthy Lives, Healthy People, the Government of the United Kingdom committed to developing a new vision for services that reflected the public health nursing role in the school community. The School Nursing Development Programme focuses on improving the life chances of children and adolescents through effective preventive services and providing early intervention and support. The Programme has been developed within the context of the Healthy Child Programme for children 5–19 years old, recognizing the importance of health and well-being among children and adolescents and the key role of school nurses in providing support during these developing years. Children and parents were not always clear about the services available. A service model for school nursing was developed based on levels around the theme of safeguarding. The levels outline the continuum of support that children and adolescents can expect to receive from school nursing services and multidisciplinary work. School nursing is a universal service, which also intensifies its delivery offer for children and young people who have more complex and longer-term needs (universal plus). For children and adolescents with multiple needs, school nurse teams are instrumental in coordinating services (universal partnership plus).

The vision of the school nursing team was to provide an integrated service model that understands and promotes the dynamic process of interaction between the child, the family, the school and the community. The new role of the school nurses included increasing the awareness of the impact of caring roles on children and young people, using early identification tools and public health profiling to determine needs, providing expertise with integrated packages of care and working with schools to improve attendance and educational attainment. School nurses also worked in partnership with other agencies and as part of a wider multidisciplinary team to support the health and well-being of school-aged children.

School nursing teams provided a range of skilled activities and communication at the individual, group and community levels. School nurses supported improvements for children and adolescents, including improvements in readiness for school, population vaccination coverage and the emotional well-being of children. Further, the project reduced school absence, tooth decay among children 5 years old, excess weight and alcohol and drug misuse. To ensure the implementation of the new model in accordance with the wider health policy framework, school nurses worked with numerous stakeholders, such as teachers, local authorities, youth services, colleges and higher education institutes.
Subtheme: governance

36 Finland – Culturepath – learning through experiences outside the classroom


In the City of Turku, Finland, the Education Division and Recreation Division created Culturepath as a joint concept. It entails all students in primary and lower-secondary school (7–16 years old) being introduced to art and cultural activities and the city’s architecture. Turku adopted the Culturepath concept in 2004. Being the first cultural education plan of its kind, it has served as an example for similar activities in many other cities in Finland.

The purpose of the Culturepath cooperation is to ensure that all students have equal opportunities to enjoy art and culture regardless of their family’s financial, social or cultural situation. Every student visits cultural institutions about three times per year. Schools can ensure that students learn more during the visits by providing the students with materials in advance. After each Culturepath visit, the students reflect on the art experience at school by means of blog writing, for example. Culturepath combines study visits required by different school subjects and curricular themes into a systematic annual programme. The content of Culturepath visits is part of the content of the cultural education plan and school curricula.

The cultural institutions of the City of Turku (museums, library, orchestra, theatre and nongovernmental cultural organizations) ensure that the comprehensive basic programme included in Culturepath is available to all schools.

37 France – Improving the health of school-age children


Each ministry has a senior official designated as the nominated contact person for health. Intersectoral action in health has a long history in France, including the agriculture and health departments (French National Nutrition and Health Programme since 2001) and the education and health departments (Health Education Programme 2011–2015). The 2014 Health Act established a new mechanism, an Inter-Ministerial Committee for Health, to be chaired by the Prime Minister and bringing together all the relevant departments (whole of government). The Committee’s first meeting was scheduled in 2016 on the topic of antimicrobial resistance.

The Ministry of Health promotes a health democracy concept with health stakeholders invited to co-create public health policy at all levels. This is not yet a whole-of-government approach because it is initially designed to create closer relationships between the regional health agencies and local authorities.

Most ministries have representatives in the regions who are accountable to the prefect, the Prime Minister’s representative at the regional level. Three ministries (education, health and justice) have their own territorial configurations that do not report to the prefect. The
Department of Health works through regional health agencies. There are also regional public policy coordination commissions that include all public entities influencing health such as local branches of health insurers.

As part of the intersectoral activities for health among school-aged children, there are some shared budget mechanisms: for example, the Ministries of Agriculture and Health co-fund activities related to obesity prevention in children.

A new concept of the parcours éducatif de santé (educational pathway of health) is designed to support well-being in schools. The Ministry of Health sets the children’s health goals, and the Ministry of Education is responsible for the health outcomes.

It has been challenging to get other ministries involved. There are legal agreements between the Ministries of Health, Education and Social Affairs, and this makes collaboration easier.

### 38 Ireland – Intersectoral national policy framework for children and young people

**Source:** Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

Better Outcomes, Brighter Futures: the national policy framework for children and young people 2014–2020 is an intersectoral programme in Ireland that adopts a whole-of-government approach to look to the future and identify how to best deliver positive outcomes for children in the areas of early years, youth and education. It is rooted in a sector-wide determination to make Ireland one of the best small countries in the world in which to grow up and raise a family and in which the rights of all children and young people are respected, protected and fulfilled; in which their voices are heard and in which they are supported to realize their maximum potential now and in the future.

The policy framework provides for a range of policy commitments across government departments, with a clear emphasis on the evidence-informed approach, coupled with a transformational agenda and goals. The framework identifies 163 action-focused commitments involving intersectoral arrangements at the highest level of government.

Better Outcomes, Brighter Futures provides for:

- establishing a shared set of outcomes for children and young people towards which all government departments and agencies, statutory services and the voluntary and community sectors will work to ensure a coherent response for children and young people;
- putting a range of policy commitments in place across government and progressing these based on a structured, systematic and outcome-focused approach;
- emphasizing an integrated and evidence-informed approach to working across government horizontally and vertically that transfers to all sectors and settings working with children and young people; and
- giving priority to key cross-cutting transformational goals under each outcome area, which requires concerted and coordinated action to realize the respective outcomes.
The Minister for Children and Youth Affairs recently convened one interdepartmental group in the context of Better Outcomes, Brighter Futures that focused on early childhood care and education to ensure equitable access for all and that is now guiding the future direction of early-years policy.

Among the recommendations being implemented include:

- providing additional resources in the 2016 budget; and
- significantly expanding the Early Childhood Care and Education Scheme (Ireland’s free preschool service):
  - to ensure equitable access and accommodation for children with disabilities;
  - to ensure that child can use free preschool services from age three years until they transfer to primary school;
  - to develop new qualification requirements for childcare workers.

One of the commitments in Better Outcomes, Brighter Futures is to implement the Area-Based Childhood Programme to address the impact of child poverty and improve child outcomes. This programme is operational in 10 areas of disadvantage. It is an innovative prevention and early intervention initiative consisting of committed funding for an area-based approach to helping to improve outcomes for children by reducing child poverty. The focus of the programme covers children’s health and development, children’s learning, parenting and integrated service delivery. Areas are implementing a range of programmes and services in a variety of settings, including schools, early-years settings and the home. Emphasis is placed on enhancing interagency collaboration to ensure services being delivered are timely, accessible and have the potential to become mainstreamed.

The key lesson learned from two years of implementation of Better Outcomes, Brighter Futures is that the voice of children (the target group) is crucial to invite, encourage, engage with and listen to. This lesson was translated into policy in September 2016 with A Healthy Weight for Ireland, Obesity Policy and Action Plan, 2016–2025. A fundamental part of the development process was continual engagement with and consideration of the voice of children and their views on the future means of implementation for the programme. At the same time that the obesity policy and action plan was published, the Minister for Children and Youth Affairs published Healthy Lifestyles – Have Your Say: a report of consultations with children and young people. The report of the consultations outlines the views of children and young people on what helps them and what challenges they face in having healthy lifestyles. Actions in A Healthy Weight for Ireland directly address the issues raised at the consultations with children and young people, including those on the importance of healthy food, physical activity, smoking, the home, schools and the local areas, highlighting the importance of these consultations.

Also in 2015, local community development committees have been established in each local authority area. The purpose of this is to bring a more strategic, joined-up approach to local and community development. Children and young people’s services committees connected with these local community development committees, with local government and the national Child and Family Agency provide the local mechanism for giving priority to local action to address issues relating to children and young people. This has shown that action at the local level is crucial, not simply to implement and monitor programmes but to be equal partners...
throughout the policy development process as well. This is important for sustainability, as it increases ownership by local authorities and local communities.

The Irish experience also suggested that ensuring intersectoral action and programmes are mainstreamed rather than being implemented as projects increases the likelihood that the sectors will maintain cooperation. This is because the work is considered core business, as opposed to merely a short-term project, therefore increasing interest from both sectors, since they see greater potential for developing further work over time and increasing levels of ownership.

The need to engage the people who are most excluded in society is also crucial. Nevertheless, a consensus has yet to emerge on how the health sector does this to ensure that it is not merely a consultation process but rather genuinely fosters lasting engagement, and this is still a major challenge. Addressing these issues is part of making the future approach transformational.

Ireland’s experience showed that intersectoral action is challenging and requires considerable effort, input and investment to achieve effectively. This is especially true when intersectoral projects have to break down the traditional vertical model of policy-making and replace it with a participatory intersectoral approach. Despite the challenges, however, the impact is much more encompassing than vertical sector-specific approaches.

**Subtheme: health, HIV, substance use prevention and skills-building education**


The 2012 Law of the Republic of Armenia on Human Reproductive Health and Reproductive Rights enforces the rights of adolescents to:

1. sexuality education and the protection of sexual and reproductive health;
2. be informed about issues of puberty and sexual and reproductive health; have knowledge about induced termination of pregnancy and sexually transmitted infections, including adequate means of HIV prevention; and
3. have access to accurate, comprehensive medical counselling and, whenever necessary, to health-care services related to puberty and sexual and reproductive health in a supportive and confidential environment.

In 2008, the Government of Armenia introduced a training course, Health Lifestyle, into the curriculum for grades 8 and 9 in general education institutions. In 2010, the course was also added to the curriculum for grades 10 and 11. The course is part of the general curriculum subject basics of life safety and physical training. Healthy Lifestyle teaching comprises 14 learning hours per year within the total number of learning hours designated to this subject. The influence of psychoactive substances on human bodies and lives is studied in grades 8
and 10 during five learning hours. Smoking, alcohol and drug use are viewed in the context of bad habits that may destroy health and cause addiction, with harmful consequences. Grade 10 students learn about the increased risks of sexually transmitted infections associated with alcohol and drug use and about ways to abstain from bad habits. To support this, special lessons are held in grade 8 to develop students’ decision-making skills and to train them in withstanding peer pressure (how to say no), and in grade 9 students discuss healthy family and interpersonal relations and learn how to deal with stress without turning to psychoactive substances. In grade 10, students consolidate their knowledge by discussing responsible behaviour and abstinence from bad habits. In grade 11, the consequences of injecting drug use are discussed in the context of HIV prevention. The course piloting showed an increase in students’ knowledge of the topics studied from 40% up to 75–80%.

40 Azerbaijan – Life skills education in Azerbaijan


According to the General Education Concept (National Curriculum) and the State Standards and Programmes (Curriculum) of General Education, life-skills education has been part of the compulsory subject of life skills since 2010. The subject consists of four thematic blocks: people and nature; individuals and society; public morals; and health and safety. Life skills is taught in grades 1–9 in all of Azerbaijan’s schools, in various formats: lectures, talks, discussions, competitions, role-play games and peer education sessions. Students build up knowledge about healthy lifestyles and develop and improve skills related to safer behaviour, health-conscious relationships and a healthy environment. Schools often invite health workers to conduct talks and deliver lectures on a healthy lifestyle. Discussions and meetings with experts are held both during school hours and as part of extracurricular activities.

41 Belarus – Substance use prevention


The following framework documents have been developed and approved in Belarus to ensure that the healthy lifestyle promotion mechanisms are sustainable and to create conditions to teach and motivate children and adolescents to undertake safe and healthy behaviour:

- concept of HIV prevention in educational institutions (2007);
- concept of the implementation of the peer-to-peer principle in educational institutions (2010); and
- concept of promoting a healthy lifestyle among students in educational institutions (2010).

In 2012, the optional basics of life safety course became compulsory for students in grades 2–9 of all general education schools. The course encourages health-conscious and responsible attitudes towards personal and public safety and develops students’ mental resilience in stressful and emergency situations. In grades 2–4, the course comprises 16 learning hours per year, and in grades 5–9 it comprises 35 hours. The curriculum has been developed to fit the
local context and age of students, allowing for a step-by-step increase of knowledge about environmental hazards and protective behaviour. In total, five of 35 learning hours in grades 5–9 are devoted to health-related topics. The remaining hours cover traffic rules, fire safety and behaviour in emergency situations.

Belarus has also developed a system of traditional prevention activities that include: prevention days and health campaigns offering lectures, consultations, conferences and discussions; meetings with researchers, doctors and sportspeople; and distribution of informational materials (booklets and leaflets) on substance use prevention and other important issues.

Effectiveness of prevention activities

Research on the prevalence of and knowledge about substance use was carried out in Belarus in 2011–2012 among general, professional, vocational and secondary specialized school students. A total of 3000 students aged 16–17 years took part in this representative survey. Even though substance use is associated with an increased risk of HIV infection, about 25% of the respondents did not select injecting drug use as a possible route of HIV transmission.

Some 79% of respondents found it unacceptable to use any type of drugs. Smoking and alcohol consumption were perceived as the personal choice of every individual by, respectively, 80% and 40% of students. One third of the students thought that such behaviour is appropriate after reaching the age of majority. Describing what they felt towards people who use substances, most students reported indifference towards those who drink alcohol and fear of drug and solvent users.

Some 53% of the respondents had smoked cigarettes at least once in their lives, 71% had used low-alcohol beverages, 47% had consumed strong alcohol, 6% had used soft drugs, 1% had used hard drugs and 2.5% had used solvents.

Among the reasons for choosing not to smoke were health risks (63%), the development of addiction (53%), the high cost of cigarettes (34%), the fear of death due to smoking-related illnesses (34%) and the risk of upsetting relationships with people with whom they are close (28%). With regard to alcohol, the above factors were supplemented by the risk of inappropriate behaviour (48%) and, for drug use, by the threat of imprisonment, loss of employment and social disapproval (about 50%).

Without estimating the effectiveness of existing prevention education programmes or attributing the survey results to the impact of such programmes or the lack thereof, the survey’s authors recommended that teachers and psychologists give priority to the following activities:

- train students in personal and social communication skills, the ways to establish social contacts and the ability to say no (including to drugs, when offered) and to defend one’s position;
- encourage students (especially those negatively affected by substance use) to improve their self-confidence, withstand negative influences and build skills for turning for help to family and people with whom they are close; and
- promote knowledge about a healthy lifestyle and encourage a willingness to engage in it.
42 Estonia – Sexuality education


Human studies is an integrated intracurricular programme currently taught in Estonia that contains sexuality education for grades 5–7. The development of the curriculum began gradually in the 1990s through the work of a partly voluntary subject commission that received some support from the Ministry of Education. In 1996, a new national curriculum established a programme on the compulsory subject human studies, which included sexuality education. The curriculum was updated during 2000–2002 to respond to societal changes, increased incidence of HIV and greater curricular concerns. In 2010, following a 10-year preparation period, a revised and updated version of the curriculum was introduced. The latest version is designed to focus greater attention on preventing risky behaviour and more clearly defining the topics on health and sexuality education. The programme is delivered alongside youth counselling centres, which were established in the 1990s to provide young people with free sexually transmitted infection counselling, tests and treatment and counselling on safer sex and family planning. Counselling centre staff are also involved in delivering the curriculum by supporting teachers on difficult topics, using interactive teaching methods, and familiarizing students with the centres’ services and facilities. The results of evaluation studies show that there has been a marked increase in the topics related to sexuality and reproductive health discussed and the lessons delivered since the programme was first introduced.

The cost of rolling out the programme was US$ 5.6 million. Between 2001 and 2009, an estimated 13 490 negative health outcomes were prevented, including 4280 unintended pregnancies, 7240 incidences of sexually transmitted infection transmission and 1970 HIV infections. In a cost–benefit analysis, based on the number of people avoiding acquiring HIV infection and on HIV treatment costs alone, sexuality education would only have to be responsible for 4% of all the people avoiding becoming infected with HIV to be considered not only a cost-effective intervention but a cost-saving one too.

43 Finland – School-based sexuality education and sexual and reproductive health services


In Finland, school-based sexuality education and sexual and reproductive health services for young people were introduced in 1990, leading to an immediate decrease in teenage pregnancy rates. However, owing to budget constraints, both programmes were drastically reduced in the period 1998–2006. This had an immediate impact on abortion and birth rates among 15–19 year old girls. The rates decreased again after sexuality education and youth-specific health services were reintroduced in 2006.
44 Kazakhstan – Healthy Lifestyle programme 2008–2016

The national Healthy Lifestyle programme 2008–2016 (approved by government decree) supports the implementation of programmes that aim to inform the general public, including key populations, about safer behaviour, HIV prevention and life skills. According to this programme, the National Centre for the Development of Healthy Lifestyles is responsible for coordinating the state policy on healthy lifestyle promotion among adolescents and young people. The National Centre for Healthy Lifestyle Promotion, which operates under the auspices of the Ministry of Health, regularly develops guidance materials and tutorials on substance use prevention – video, audio and television programmes.

The education sector promotes healthy lifestyles by means of formal education and extracurricular activities with the participation of health workers. In accordance with the Compulsory State Standards for Secondary Education approved in 2012, topics related to life skills development and healthy lifestyle are delivered as part of the mandatory subject basics of life safety. In primary school (grades 1–4), this course has annual teaching time of 6–10 hours. In grades 5–9, basics of life safety is delivered as part of the physical training course, covering 15 hours per year. In grades 10–11, life safety–related topics are taught as part of the initial military training and are allocated 25 hours. In general, the basics of life safety subject mostly focuses on road safety, fire safety and emergency situations. In grades 7 and 8, the self-knowledge subject (mandatory for grades 1–11) helps students to analyse negative stereotypes and dangerous temptations and assess their development needs and actions to abstain from bad habits (alcohol, smoking, drugs, etc.). Biological aspects related to substance abuse are part of the mandatory biology course. Issues associated with preventing drug use, smoking and drinking alcohol are also discussed during thematic homeroom sessions.

45 Kyrgyzstan – Law on Health Care of the Kyrgyz Republic

The Law on Health Care of the Kyrgyz Republic guarantees hygiene education for minors, and the Law on the Reproductive Rights and Guarantees of their Implementation warrants the right of children and adolescents to “protection of their reproductive rights as well as the right to education in the spheres of sexual and reproductive health and preparation for family life”. The Law on HIV/AIDS shapes up state guarantees, including those related to the introduction of thematic sections on HIV and AIDS into educational curricula.

The Ministry of Education and Science has approved the activities and time frame of the WHO Health Promoting Schools project, which is gradually being introduced in schools across the country. Participating schools teach the culture of health subject in grades 1–8. In 2014, the Kyrgyz Academy of Education (under the auspices of the Ministry of Education)
adopted a guide for teachers to facilitate homerooms on healthy lifestyles for all students in grades 6–11 in all general education schools. The curricula cover topics related to effective communication, violence and conflict prevention and resolution, prevention of HIV and sexually transmitted infections, unintended pregnancy and substance use. It discusses gender, sexuality and reproductive health and rights and addresses early marriages, adolescent pregnancy, family planning and family life. Every year, schools reach up to 85% of students with prevention education in the form of homerooms, out-of-school campaigns, discussions and round tables with participation of health and youth workers and peer educators.

46 Netherlands – Long Live Love


Long Live Love (Lang Leve de Liefde – LLL) is a stand-alone intracurricular programme developed for secondary schools in about 1990 by the Dutch STI Foundation (now STI AIDS Netherlands). An initial version (LLL1) began during 1990–1992 and has subsequently been revised three times to incorporate updated educational approaches and changes in the sociocultural environment, such as changing risk factors, the need for more information on sexually transmitted infections and HIV and the need to strengthen the focus on gender equity and minority groups. Sexuality education is not compulsory in the Netherlands but is usually adopted by schools, with LLL being the most commonly used curriculum. The Dutch STI Foundation manages programme and curriculum development, municipal health services train teachers and the Ministry of Education pays implementation costs (teachers’ salaries). During 2009–2010, LLL4 was developed, for implementation in 2011. Updating of the programme every 5–10 years has addressed changes in youth culture and images and incorporates new research and educational approaches as well as emerging challenges and risks. Over this period, the curriculum has also been adapted for more target groups among people 13–15 years old. Long Live Love is the most widely used sexuality education curriculum in the Netherlands and is implemented in about half of target schools. To address issues relevant to an increased immigrant and Muslim youth population, the curriculum addresses issues that are particularly relevant for these groups, including virginity and gender equity. The LLL3 package of students’ and teachers’ materials (magazine, manual and video) must be purchased by implementing schools and is part of a larger programme that includes a website, annual multimedia campaigns and other interventions.

47 Republic of Moldova – E-learning programme: Life and Health


According to the National Strategic Programme on Demographic Security for 2011–2025, the health-care and education systems are responsible for promoting healthy lifestyles and preventing drug use, smoking and alcoholism by delivering educational programmes and information campaigns. The programme’s action plan introduces various formats of life skills
training in the general, vocational and specialized secondary education institutions through both mandatory subjects and optional courses.

In 2012, to enhance healthy lifestyle education, an e-learning programme, Life and Health, was developed for Grades 5–12. Students wishing to take part in the course can register at www.viaturasanalatatea.md, get access codes, study the topics and take tests. The course covers the following key topics: health and healthy lifestyles; bad habits; environment and health; managing emotions; violence and abuse; personal safety; human rights; the right to health; health values; bioethics; solidarity with people living with HIV, people with disabilities and victims of crime; and sexual exploitation and its consequences. In grades 7–8, students study issues related to psychoactive substances, their effect on the human body and preventing addiction.

48 Russian Federation – Everything That Concerns You


The Law on Education of the Russian Federation ensures that all educational institutions enforce comprehensive measures to protect students’ health and measures for developing healthy living skills. The state ensures that prevention education on socially significant diseases and the moral and sexual upbringing of young people is included in the national curricula. Sections on HIV prevention and reproductive health, prevention of substance use, personal hygiene and daily regime have been officially integrated into the curricula of school subjects such as biology, basics of life safety and physical training. In grades 10–11, students also study such issues as healthy living; reproductive health; infectious diseases, including HIV; and first aid. In most schools, four hours are allocated to a discussion of these issues of 140 learning hours devoted to basics of life safety.

In 2007–2012, a Russian NGO called the Health and Development Foundation supported the implementation of an optional interactive prevention programme called Everything That Concerns You, which reached more than 400 000 students in the general and vocational schools and residential institutions. Designed for adolescents aged 13–17 years, the programme aims to improve health outcomes among adolescents, prevent risky behaviour (drug use, alcohol consumption and smoking), motivate young people to lead healthy lives and foster responsible attitudes to their own health. Built on the principles of life-skills education, the programme includes 17–19 interactive training sessions lasting 1.5–2 hours each, which are held once or twice a week. The total duration of the programme is 3–6 months. The programme develops communication and conflict resolution skills, critical thinking and resisting pressure, teaches behaviour in stressful and crisis situations, increases self-confidence and shapes tolerant attitudes. Students discuss life values, learn to build healthy, non-violent relationships, develop critical attitudes towards smoking and drug use and study the risks related to substance use, including injecting drug use. Several training sessions are devoted to preventing HIV and sexually transmitted infections. Students consider their future and life values, which enables them to appreciate the impact of their own health and safe behaviour.

The impact of Everything That Concerns You has been evaluated through surveys of students in participating regions. In the Irkutsk region, where HIV and drug use rates are extremely
high, 200 boys and girls took part in the training programme and demonstrated the following results. The proportions of respondents with improved knowledge about the potential consequences of smoking, including the risks of malignant tumours, male impotence and female infertility, increased by 12–17 percentage points; the share of those who recognized the danger of smoking in the long term increased by 11 percentage points (from 44% to 55%) and in the short term by 7 percentage points (from 27% to 34%); the proportion of those who thought that drinking a lot of beer was less dangerous than drinking a lot of vodka was halved (from 40% to 21%); the share of those who correctly identified the harms alcohol can cause increased by 9 percentage points; and those who correctly identified the harms and consequences of drug use increased by 14 percentage points; the share of those who found drugs unattractive increased from 3% to 27%, and the proportion of those who would never use drugs under any circumstances increased by 11 percentage points.

49 Ukraine – Health in schools


In 2000, the Ministry of Education and Science of Ukraine introduced basics of health as a compulsory subject for grades 1–9. Being delivered on a weekly basis, it integrates topics related to healthy lifestyles and safe living, promotes responsible attitudes towards life and health and develops essential social and psychological skills. Basics of health offers the most comprehensive and thorough study of issues related to sexual and reproductive health and behaviour. The course covers the following topics: family, friendship, love and marriage; puberty and reproductive health; prevention of HIV, sexually transmitted infections and unwanted pregnancies; abstinence; fidelity; means of protection; sex and gender; harassment and violence; human rights; human values; social norms and stereotypes; communication skills, conflict resolution and decision-making; promoting tolerance towards people living with HIV; and ecological competence, security problems and sustainable development.

In addition to the obligatory subject basics of health, Ukraine’s schools offer several optional prevention education courses. One is delivered to 15- to 18-year-old students at schools and vocational training schools and is entitled Protect Yourself from HIV. It comprises 17 training sessions and two tests (taken before and after the course), delivered in 35 learning hours. An evaluation of Protect Yourself from HIV carried out in 2006–2007 demonstrated that the level of knowledge in all thematic areas (modules) had increased 24-fold (from 1.4% to 34%); the proportion of students with the skills to refuse unwanted sexual relations had grown by 11 percentage points (from 63% to 74%); and the share of students who had reported a strong intention to delay the onset of sexual activity until marriage or they were more mature had increased by 13 percentage points (from 71% to 84%). The proportion of students with the capacity to make responsible decisions about the use of condoms rose by 27 percentage points (from 57% to 84%).
Subtheme: nutrition, obesity and physical activity

50 Andorra – Nereu Programme: using an intersectoral approach to tackle childhood overweight and obesity


The Nereu Programme aims to promote change and maintain healthy habits among overweight and obese primary school children by offering regular opportunities for physical activity, promoting healthy eating and working with families. Nereu seeks to reduce the prevalence of obesity in the country in accordance with Andorra’s Health 2020 goals. The Nereu Programme aims to reach 60% of overweight or obese children in the country. In Andorra, the prevalence of overweight is 8% and obesity 5.5% among 11- to 12-year-olds.

In Andorra, the health, education and sports sectors have a history of working together in an Education for Health programme and implementing actions pertaining to the National Strategy for Nutrition, Sport and Health. The Nereu Programme uses an intersectoral approach involving the health, sport and education sectors and provides equal opportunities for participation, regardless of sex, income, education or fitness levels. Participation fees are waived for financial reasons.

In 2015, a pilot programme was carried out in seven schools in Andorra and included overweight and/or obese children with low levels of physical activity. Children received three weekly extracurricular physical activity lessons, practiced new sports and received information on healthy eating and active lifestyles. Families received two monthly behavioural counselling sessions on healthy eating and physically active lifestyles.

The Nereu Programme is led by the Ministry of Health and promoted in partnership with the Ministry of Education and the Ministry of Sport. The main triggers for Nereu were data from the first national nutritional survey in 2004 showing increasing levels of overweight and obesity, WHO overweight and obesity recommendations and the 2007 National Strategy for Nutrition, Sport and Health.

The health sector leads and coordinates the Programme and is responsible for managing user data, monitoring and evaluating the pilot phase and making necessary adjustments. Associaciò Nereu, an NGO, coordinates, monitors and supervises implementation. Dietitians provide counselling sessions to Nereu families. The Ministry of Education manages the extracurricular sports activities and reports on progress to all involved sectors. The state sports secretariat has engaged sports clubs and informed sports facilities about Nereu. The Andorran School for Training for Sports and Mountain Professions will provide sports counsellors for the extracurricular activities. The mass media have been involved through a press conference presenting the Programme and an interview on Andorran television.

An intersectoral committee was set up between the Ministry of Health, the Ministry of Education and the Nereu Association, with regular meetings held. The Ministry of Education used their intranet to keep internal stakeholders informed, and a Nereu web-based platform was also set up for coordination.
Nereu brings the primary health-care system benefits in terms of preventive action to reduce obesity and increase physical activity and to reduce the long-term burden of noncommunicable diseases. Although the Ministry of Health’s budget primarily funds the Programme, the Ministry of Education funds physical activity sessions.

The involvement of primary care professionals is essential for Programme success. Their role in the community as the first contact with the health-care system and in identifying families with children who could benefit from the Nereu Programme is key.

The main challenges or barriers to better Programme performance encountered are the work schedules of families, many of whom are employed in the tourism sector and have shift work schedules that do not permit them to attend family counselling sessions. The existence of extracurricular sports programmes, good working relationships with the Ministry of Education and their willingness to take an active role in the programme have been facilitating factors.

The Nereu Programme was very well perceived and accepted by the population initially, but full family participation dropped, possibly because of fear of child stigmatization or work schedule conflicts. The full involvement of primary care professionals in the project will help improve programme performance, since they are the common thread that will link families with other sectors and initiatives such as the Nereu Programme.

The pilot programme ended in 2015. Full implementation of Nereu is beginning in September–October 2016.

51 Denmark – Food in schools


Students from ethnic backgrounds other than Danish in a deprived area of Copenhagen were invited to become actively involved in developing a new school canteen. The project focused on many dimensions, including food quality, preparation and preferences and the canteen’s aesthetic qualities. The new canteen now offers four meals daily, with children participating in the kitchen (in collaboration with trained professionals) as part of their home economics classes. Meals are partly paid by parents, but families with three or more siblings receive a discount, and a free school meal entitlement scheme is available for those who are especially disadvantaged. The City of Copenhagen partly funds the operation of the initiative and the operating costs of the production kitchen.

The project has improved healthy eating among students and boosted social capital at the school. It demonstrates the importance of student participation in developing their sense of ownership and improving their health.
52 France – Experience of the National Nutrition and Health Programme

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

The Prime Minister initiated a National Nutritional and Health Programme in France in 2001. Intersectorality is at the root of the policy. It is administered by a steering committee bringing together many different ministries (Agriculture, Education, Consumption, Social Affairs, Research, Internal Affairs and public health agencies) and coordinated by the Ministry of Health. A follow-up committee was also established to discuss elements of the Programme, which includes representatives of local authorities, the food economic sector and consumer and patient associations. Its main objective was to improve the state of health of the whole population by acting on one of the main determinants: nutrition. Policies under the Programme are comprehensive, including developing educational tools for nutritional education in schools, regulating commercial marketing in the school setting, banning vending machines in schools (since 2005), limiting snacking at school and even parents participating in “meals commissions” in some schools.

Although the programme has been successful, implementation faced many challenges, including adapting local specificities, the need for consistency and coherence among all levels, sectors and actors and the right appreciation between collaboration and partnership. Delegating responsibility among levels of governance can also be testing: depending on the context, national, regional, municipal or local levels – with the full participation of civil society – may be most effective or most appropriate. Public–private collaboration also raises challenges, as does the extent to which NGOs should be involved in developing or implementing government-run policies and programmes. A lack of available capacity to conduct follow-up evaluation also contributes to a lack of data, lowering the transferability of the policy.

53 Israel – National Program for Active and Healthy Living

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

Israel recently launched the National Program for Active and Healthy Living among the whole population, not only children. The Program has strong intersectoral collaboration built in, including a specific pathway for healthy schools within the Program. The national, regional and municipal levels are all strongly involved and equal partners in the Program. The aim of the Program is to ensure that all schools are health-promoting schools by 2020; the current figure is about 20%.

The Ministry of Health and the Ministry of Sport have achieved strong collaboration to promote physical activity to children both in and out of school.
54 Malta – A whole-of-school approach to healthy lifestyles: healthy eating and physical activity


The major health challenge affecting schoolchildren in Malta is overweight and obesity; almost 47% of 11-year-olds in 2012 were either overweight or obese, with boys showing an increasing trend and girls’ obesity declining. This rapid increase motivated the health and education sectors to join efforts to implement a national school-wide policy and strategy to increase physical activity and improve nutrition in schools for all children.

The strategic goals of the initiative were:

- to achieve better physical activity and nutrition for all schoolchildren in Malta; and
- to create a level playing field in all schools by offering equal opportunities for all children to engage in physical activity and benefit from improved nutrition in school settings.

The whole-of-school approach to healthy lifestyle healthy eating and physical activity aims to increase opportunities for physical activity and improve nutrition in schools while allowing the schools to propose locally appropriate action. One initiative taken so far has been increasing physical activity among adolescents in secondary schools. To achieve this, a health, education and sports working group was set up and dance sessions are offered to students during class breaks. Active changes in foods being sold in school-based snack shops (“tuck shops”) have also taken place.

The policy and strategy, jointly implemented by the health and education sectors, was triggered by the growing prevalence of obesity among children. Intersectoral action has built on existing relations with the education sector; this was an opportunity to identify common goals and work towards them.

The highest levels of government were involved in developing policies and strategy; the education and health sectors shared the lead. Many levels of society were involved. Parent associations were consulted during the development of the policy. The media played an active role in promotion and disseminating information. Tuck shops changed their purchasing choices. Cereal companies were informed of the mandatory nutrient levels and sought to promote healthy cereals.

Mechanisms to facilitate work included the ministers themselves establishing an intersectoral working group. They also launched events emanating from the policy such as a lunch box campaign using television, radio and social media. School-based initiatives such as cooking classes on healthy meals for children and parents were offered. Preparatory work for the initiative was facilitated by a strengths, weaknesses, opportunities and threats (SWOT) analysis and policy reviews to assess feasibility.

No additional funding was required for policy and strategy. Each sector used its own budgets and staff time. The positive impact of intersectoral collaboration is apparent in other sectors. The sports sector, previously promoting elite sports, now promotes health-enhancing physical
activity at schools. During the summer, children can enrol in non-competitive swimming classes.

Successful intersectoral collaboration requires that the goals of each sector be complementary; conflicting goals impede smooth work. The action needs to be logistically feasible. Building up personal relations and identifying a champion from each sector is key. Commitment of people working in the field and at the policy level facilitated this process. Schools being involved in developing the policies supported their ownership of the initiative.

This initiative had equitable strategic goals; both policy and strategy sought to ensure that all children would be equally exposed to opportunities for physical activity and good nutrition. With regard to public participation, parent associations actively provided input into the process. The media were also involved in various stages promoting and disseminating information to the public.

The whole-of-school policy was launched in January 2015 and is currently being implemented.

55 Netherlands – Providing healthy choices and supportive environments at school


The health and education sectors in the Netherlands have engaged in long collaboration to start and/or improve health initiatives at schools throughout the country. The Healthy School Programme aims to have 850 schools successfully implementing health promotion activities by the end of 2016. Specific goals are improving health literacy, with a specific focus on sexual health, and reducing child obesity. For obesity, 26 public and private partners have come together in a working group that offers healthy food in the canteens at schools and sports clubs.

56 Republic of Moldova – Physical education for health in preschool education

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

The 2008 Strategy for Preschool Education in the Republic of Moldova strongly focuses on physical education for health. The strategy promotes personal hygiene, physical education and ecological education throughout all levels of the education system. The strategy noted the co-benefits that could be achieved by the health and education sectors working together.

One issue raised by the Republic of Moldova was the notion that wider society could both present represent significant challenges and comprise potential partners in interventions. The
example of the integrating children with disabilities and learning difficulties into mainstream schools was given. The greatest challenge in this integration stems from public mentality and existing social stigma. Opposition comes from civil society, parents, teachers and other members of the community. Overcoming this opposition requires a shift in cultural understanding, which can only be achieved by all relevant sectors working and engaging with society to educate them about the rights of children with disabilities or learning difficulties.

57  San Marino – EXPO Milano 2015: an opportunity to highlight the importance of nutrition and sustainable agriculture in school settings


According to data from the WHO European Childhood Obesity Surveillance Initiative in 2014, 31% of primary school children in San Marino are overweight or obese. This case story reports on incorporating nutrition and agricultural components into an existing project on nutrition in schools. It shows how intersectoral action and an international event (EXPO Milano 2015) can promote balanced diets and food quality standards that prevent overweight and obesity among children.

The strategic goal was to ensure that all children in San Marino have access to sustainably grown nutritious foods in school and educational opportunities to learn about these foods. Gender, equity and human rights were implicitly considered; all children in San Marino are offered these foods at school. EXPO Milano 2015 provided an opportunity to strengthen a project on nutrition in schools already in place while providing education to children on the importance of food quality.

Two congressional resolutions backed up this process. In 2013, a congressional resolution was passed calling for establishing a multidisciplinary and intersectoral working group for planning and coordinating the health promotion and education interventions in schools. Another congressional resolution on EXPO Milano 2015 focusing on promoting balanced diets and food quality standards was also passed.

Sectors took turns leading. The health ministry, with the support and coordination of the health authority, provided guidelines on health education in school settings and guidance to dietitians and paediatricians on menu development and special diets. The education ministry ensured a link between school science lessons and off-campus workshops. The tourism ministry, responsible for the San Marino exhibit at EXPO Milano 2015, highlighted agricultural production in San Marino to the outside world. The agriculture sector (Terra di San Marino agricultural consortium) organized workshops for schoolchildren on their various products. They agreed to follow several integrated agriculture standards that would help ensure sustainable production of the six main food products. The media highlighted and promoted best practices, broadcasting programmes highlighting food quality and healthy diets.

Although the consultative committee for EXPO Milano 2015 had a time-specific mandate, the education for health working group will ensure sustainability. EXPO Milano 2015 had its specific funding, and the initiative built on activities already in place.
Although it is early to see any health effects or decreases in obesity, indirect evaluations carried out every two years such as Occhio alla Salute will provide indications of change in overweight and obesity. Intersectoral work was successful, with an indicator of interest being high attendance at nutrition workshops organized by the agricultural consortium (1500 children). Other elements to be evaluated are the effect of direct training of cooks by the Social Security Institute dietitians, knowledge passed on to children by teachers in science lessons and the results of a dietary assessment of third-grade children.

If there is strong government support, a mechanism such as the education for health working group can be activated. Riding the wave of EXPO Milano 2015 provided an opportunity for the country to bring together all their skills to work on a common project. An understanding by all stakeholders of integrated work helped streamline work and led to better coordination. Finding a common language between schools and the health sector as well as identifying goals that were of mutual benefit were also challenges that were overcome.

Although EXPO Milano 2015 has concluded, the education for health working group remains intact and the agricultural consortium continues to supply school cafeterias with sustainably grown healthy foods.

58 Spain – Alimentation and Physical Activities in the Eastern Valles (AVall)


Obesity has become a global public health problem, with especially serious effects for children. It has been proposed that educational interventions during childhood could provide a key prevention strategy, with education on dietary habits and physical activity for children and their families being considered the foundation for healthy lifestyles in adulthood. Alimentation and Physical Activities in the Eastern Valles (AVall) was launched as a prospective study in 2006 in Granollers, a town situated in the northern metropolitan area of Barcelona (Valles Oriental). Its aim was to evaluate the effect of a community-based intervention for reducing childhood obesity by educating children on the importance of healthy eating and physical activity. The evaluation measured the effects of actions on the children’s body mass index. The method focused on children’s participation through the four-stage investigation, vision, action and change approach developed by the research programme for health and environmental education at the Danish School of Education. This method views children and schools as catalysts for health promotion action at the community level and has been successfully implemented in an EU pilot project – Shape Up – in 20 EU countries. The Shape Up and investigation, vision, action and change approach differs sharply from traditional disease prevention and health promotion interventions that focus on modifying children’s behaviour by assuming that the locus of responsibility for childhood obesity (or any health problems) lies with the child. Instead, it focuses on tackling layers of responsibility and, significantly, developing the capacity of children and adolescents to critically explore and improve health-related conditions, practices and choices at different levels: family, school, community, city and even wider.
59  Regional – Shape Up Europe: a school community approach to influencing the determinants of childhood overweight and obesity


Shape Up was an intervention founded on the principles of student participation and a whole-school approach, focusing on overweight and obesity among children and adolescents. It was piloted in 20 countries in the European Union. Although the fundamental premise of Shape Up was that healthier eating and regular physical activity are keys to preventing childhood obesity and promoting the health and well-being of children and young people, the project was built on a salutogenic approach.

The starting-point was that promoting a healthy diet and physical activity are influenced in more efficient and sustainable ways by addressing their determinants on a school, family, community and broader societal level rather than solely on an individual behaviour level. Further, health was framed in the project as a positive concept; play and dance instead of physical activity, food, meals and eating instead of nutrition etc. Therefore, a key to Shape Up was involving children and adolescents themselves through their schools in investigating the social determinants of health and formulating positive and visionary proposals for action to address them.

Within the Shape Up project, the investigation, vision, action and change approach was used as a guiding framework to support children in taking concrete action to improve the determinants behind their health. In practice, this typically meant improving the quality of food on offer in school, enhancing opportunities for physical activity in the school and in community settings and increasing parents’ understanding of health issues. Because of the relationship between schools and the local promoting group, young people had the capacity to see their ideas turned into action, and the individual development promoted by the programme could be supported by changes in policy and infrastructure at the local level. The conclusion of the project was that young people are able to influence the determinants for their own health but that they need the support of adults to reach their goals.

Cooperation with the social sector

Subtheme: family and parental support

60  Belgium, Germany, Netherlands, Switzerland and United Kingdom – Parenting programmes


Among the best known parenting programmes is the Triple P – Positive Parenting Program, which aims to prevent problems among children by strengthening the skills, knowledge and
confidence of parents. Developed in Australia, Triple P offers different levels of support, ranging from media-based information to one-on-one sessions and parenting seminars, with intensive modules for at-risk families. Studies have identified positive effects of Triple P on risk factors for child maltreatment, including parenting competence and parental stress. Some positive changes in parenting behaviour have also been reported at four-year follow-up. To date, the programme has been implemented in several European countries, including Belgium, Germany, the Netherlands, Switzerland and the United Kingdom.

61 United Kingdom (England) and Netherlands – Home visitation programme


The Nurse Family Partnership is one of the most widely used home visiting programmes and has been shown to be effective in reducing child maltreatment. Originally developed in the USA, the Nurse Family Partnership has also been implemented in England and the Netherlands.

The Nurse Family Partnership provides prenatal health advice and support, child development education and life coaching for vulnerable first-time mothers. Positive effects of the Nurse Family Partnership for children include fewer injuries and improved emotional and language development. It has also been associated with improvements in health and well-being outcomes for young first-time mothers and their children.

62 Finland – A new approach to improving the health of families with children


The way a family functions has major effect on the health and well-being of children. The focus of health examinations in maternity and child health clinics and in school health care has been on either pregnant women or children’s health and well-being. Research revealed the need for wider health examinations, introducing earlier support and strengthening the empowerment of families and multiprofessional collaboration. A working group appointed by the Ministry of Social Affairs and Health developed extensive family health examinations in 2007–2009, and these were piloted in 2009–2010.

A public health nurse or midwife together with a physician conducted seven extensive health examinations during pregnancy, among preschool children and among school-aged children. The role of these professionals was enhanced to cover the assessment of health and well-being of the parents and the whole family. This meant evaluating the mental and social aspects of the family, including living conditions, income and support networks. Multiprofessional teamwork and sharing of tasks and information were also learning objectives. Information obtained from the extensive health examinations was also used in evaluating the school environment.
Extensive health examinations require theoretical knowledge of family health nursing, health promotion and noncommunicable diseases. The main skills needed are interaction based on dialogue and partnership, empowerment, early identification of needs and targeted support. Skills to intervene with difficult problems, such as alcohol, drugs and violence, are also needed. Skills and competencies were developed through continuing education and a guidebook.

Extensive health examinations comprising more than 400,000 examinations a year can strongly affect the health of children and families. According to a nationwide survey, public health nurses, midwives and physicians reported that extensive health examinations helped them to identify support needs and potential health problems earlier and enabled them to target support to the children and families most in need. Interactions based on dialogues helped parents and personnel to discover new viewpoints in the promotion of children’s health for the benefit of the entire family. Extensive health examinations emphasized the importance of the family in promoting the health of children and empowered parents as primary caregivers for their children. Since they improve health habits, they also help to decrease noncommunicable diseases.

63 Iceland – Increasing resilience by avoiding retraumatizing victims of child abuse


Iceland developed this strategy to improve the performance of its overall intersectoral system in building individual, community and institutional resilience to prevent child maltreatment. Building resilience and supportive environments for health and well-being is critically important for both preventing child abuse and promptly rehabilitating the children experiencing abuse and maltreatment. Iceland’s approach to child abuse has received much international interest and recognition, especially for the measures undertaken to avoid retraumatizing and revictimizing children.

A main feature of Iceland’s approach is the barnahus (children’s house): a child-friendly, interdisciplinary and multiagency centre in which different professionals work under one roof. The main purpose of the barnahus is to investigate suspected child sexual abuse cases and to provide psychological and therapeutic support for victims of child abuse. The government agency has a crucial role for building resilience, awareness and commitment to preventing child abuse, with activities tailored to specific target groups. Other key features and other main institutions and programmes complete Iceland’s approach within the various ministries to implement the Child Protection Act and develop supportive environments for children’s rights by fostering up-skilling training for a wide range of interdisciplinary professional groups, parents and children themselves. A main lesson that can be distilled from this inspirational example is the new insights and innovative practices that are instrumental to shift policy towards prevention and building resilience. Making the shift requires sustained and organized intersectoral and interdisciplinary efforts.
Community-level family support approaches are less frequently used, but are increasing. An example is Association Aprender em Parceria (Learning in Partnership Association) in Portugal. Portugal’s cities lack effective support for families with young children (0–3 years). At-risk families tend to be single parents, adolescents with babies and socially excluded people, many of whom are unemployed and whose children leave school early.

Association Aprender em Parceria was created to support the parents of young children in disadvantaged communities. It was developed from the peer early educational partnership model, combining individual and community approaches to promote:
- positive bonding between parents and children
- self-esteem
- positive dispositions towards learning, curiosity and confidence
- educational achievements among children, especially in literacy and numeracy
- reductions in school dropout rates
- social support between families and inside the community.

Association Aprender em Parceria groups include:
- circle time, with parents, caregivers and children being led in carefully chosen songs and rhymes to promote relationships – all families are offered a songbook containing the songs and rhymes used in the programme;
- story time, with story-telling in every session;
- book sharing, offering books for parents to share with their children during group time;
- talking time, enabling adults to discuss ideas, share experiences and offer and receive support;
- borrowing time, using a library of play packs, books and play materials offered weekly; and
- home activities, including practical suggestions for games and activities.

The mission of Association Aprender em Parceria is to create confident communities, learning together with their children. Systematic evaluation revealed that parents received several benefits in relation to their capacity to interact with their children, ability to observe their daily progress and to recognize the most important moments of interaction with their child and understanding that they are their child’s most important role models. Association Aprender em Parceria enabled them to enjoy parenting activities and seek social support. Children also appeared to show improvements in self-esteem, cognitive development, literacy and numeracy.
65 Slovenia – National Programme on Prevention of Family Violence

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

The National Programme on Prevention of Family Violence focuses on joint programmes between the health, social and education sectors. Programmes involve education on violence for at-risk families as well as education for health and social sector workers to deal with violence within families.

66 Sweden – Swedish Family Care Competence Centre


Both children and society as a whole benefit from better support to families experiencing substance abuse, physical and mental illness or death.

When a parent experiences serious difficulties, this affects everybody in the family, the family environment, parents’ mental health, the conditions for parenting, everyday life and the children. Support needs to focus on the family, the parents and the children’s needs.

It means strengthening protective factors through often quite simple measures: providing adequate information and answers to questions, helping the family to be able to talk about problems, children expressing their concerns and experiences, ensuring that they are able to have friends in their hobbies and being supported in school. Supportive relationships within the family and with any supportive adults in addition to the parents are fundamental, and parents need to seek the help and support they need for themselves and in their parenting.

Life with routines and structure is important. Practical support may be needed to relieve children and young people from the overwhelming responsibility and a heavy burden of care. The survey shows that 3% of 15-year-olds stay home from school one day a week to care to someone at home. Playing and learning in preschool and school are important protective factors. Here children need special support and extra care.

Good relationships and thereby a good childhood can counter the risks associated with any genetic vulnerability to addiction and mental illness. Tailor-made support can make families and children better off here and now – and prevent the problems from being passed on to the next generation.

Everyone benefits from it

It is also cost effective. An economic analysis shows that the societal costs in Sweden could be reduced by SEK 35 billion per year if children dealing with abuse or serious mental illness in the family do not develop this themselves in adulthood.
67 Turkey – Getting a good start in life: comprehensive study for policy and action for healthy generations in Tepebaşı


Turkey’s local governments believe that reducing inequality in health and education and eliminating the disadvantages of the main determinants of health, which are social, economic and cultural, are structural problems that need to be resolved. The Municipality of Tepebaşı uses community houses and cultural facilities, which are usually located in the suburbs of the city, to reach children and adolescents with projects and services. Expert teachers in the fields of education, pedagogy, sociology, psychology, art and sports are assigned in these social centres to provide services free of charge for children 3–18 years old.

The project provides support to mothers before giving birth to eliminate the inequality in starting a good life. It then has been continuing to support with diapers and milk for babies 6 months to 2 years old and preschool education for children 3–4 years old. Although there were no education units for children 3–4 years old in the municipality in 2009, the number of the units was then raised to 6. A total of 15% (~1100) of these age groups have started to benefit from these units. Although the average in Turkey is 22%, it has been raised to 36% in Tepebaşı. The target for 2019 is to increase this rate to higher than 50% in Tepebaşı.

68 United Kingdom: England – Troubled Families Programme

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

The Troubled Families Programme is a cross-government scheme for England led by the Department for Communities and Local Government and launched by the Prime Minister in 2011 with the stated aim of helping the 120 000 families experiencing the greatest difficulties in improving their situation. Initially, it focused on unemployment, truancy from school and antisocial behaviour. Almost three-quarters (71%) of these families had health problems according to the first evaluation. Subsequently, the Programme widened this intersectoral approach to include families with mental and physical health problems, families with vulnerable children and families affected by domestic violence and abuse when it was expanded to include an additional 400 000 families in April 2015. It seeks to challenge the repeating generational patterns of poor parenting in these families by transforming the delivery – and coordination – of local services on a payment-by-results basis. This expanded programme is supported by £200 million a year from the central government and run by troubled family teams in local authorities, supported by health and other professionals. Each family has an assigned family worker to help address their specific needs and foster links with services as necessary.
69 Regional and global – UNICEF Care for Child Development package


Care for Child Development is a landmark and holistic early childhood development intervention that was originally developed in the late 1990s as part of the regular child health visits as specified in the WHO/UNICEF strategy of Integrated Management of Childhood Illnesses. Since then, there have been other initiatives such as Accelerated Childhood Survival and Development, Infant and Young Child Feeding and Maternal and Newborn Health Care. This updated version of the package can be integrated into these initiatives as well to support families in caring for their children and helping them survive, grow and develop their full potential. The Care for Child Development intervention provides information and recommendations for cognitive stimulation and social support for young children through sensitive and responsive caregiver–child interactions.

Subtheme: governance

70 Austria – National-level Health 2020 indicators


Austria is now three years on with its health in all policies and whole-of-government health targets that started in 2011. The process constitutes the framework for the national health promotion strategy that is part of a nationwide health reform.

In Austria, 10 headline targets were formulated, which reflect the objectives of Health 2020, in an intersectoral, highly participatory endeavour over two years. The process is coordinated by the Ministry of Health but involves a plenum of 40 actors, including other ministries, institutions, organizations and civil society representatives. So far, intersectoral working groups have further elaborated four headline targets, each supported by an outcome action plan that includes specific measures and indicators proposed and implemented by sectors within and outside the health sector. Intersectoral working groups have been established for the following targets:

- target 1: to provide health-promoting living and working conditions for all population groups through cooperation among all societal and political areas;
- target 2: to promote fair, equal opportunities in health, irrespective of gender, socioeconomic group, ethnic origin and age;
- target 3: to enhance health literacy in the population;
- target 6: to ensure conditions in which children and young people can grow up to be as healthy as possible;
- target 8: to promote healthy, safe exercise and activity in everyday life through appropriate environments – a working group coordinated by the Ministry of Sports.
An update on the programme in 2016 identified four factors that were key for the process to succeed.

- Political commitment: relevant resolutions by the Council of Ministers and Federal Health Commission ensured ongoing political commitment.
- Mandate: it was part of the government programme and health reform.
- A framework for coordinated action for all targets ensured that all partners were working together and on the same path.
- High commitment and ownership of intersectoral partners ensured continued engagement from all partners throughout.

71 Bosnia and Herzegovina: Health 2020 policy in Republika Srpska


At the subnational level in Bosnia and Herzegovina, the Republika Srpska introduced a Health 2020 policy in November 2012, focusing on reducing inequities and noncommunicable diseases through multisectoral policies to promote health and address the underlying determinants, while the Federation of Bosnia and Herzegovina has endorsed two specific strategies drawing on Health 2020 values and approaches: on protecting and promoting mental health and on preventing, treating and controlling cancer. In Serbia, work is under way to integrate Health 2020 into local health policies being developing by newly established municipal health councils.

72 Czech Republic – Health 2020 policy


The Parliament of the Czech Republic passed a resolution in January 2014 proposing the development of a new Czech Health 2020 strategy by the end of 2015. Work commenced by an existing intersectoral committee on health and a specially convened Ministry of Health working group.

73 Estonia – National Health Plan 2009–2020


The National Health Plan of Estonia is an intersectoral, long-term strategy that aims to improve the health-adjusted life expectancy of Estonians. It is established by a government regulation, and its actions are mandated by different legislative decrees. The Plan for 2009–2020 details five thematic fields: increasing social cohesion and equal opportunities, ensuring healthy and safe development for children, shaping an environment supporting health, facilitating healthy lifestyles and ensuring the sustainability of the health-care system. The National Health Plan highlights that the right to protect one’s health belongs to the basic human rights, and everyone must have a possibility to live in a healthy environment and an opportunity to make healthy choices. Common values such as joint responsibility for health,
equal opportunities and justice, social inclusion and increasing the power of civil society are priorities.

The National Health Plan is implemented at national, regional and local level, and its progress is monitored by an intersectoral structure, the Steering Committee, which includes representatives from all relevant ministries and departments, quasi-governmental agencies and the society. The Ministry of Social Affairs leads the Steering Committee, acts as its Secretariat and coordinates implementation. The activities of the National Health Plan are funded from the state budget. The yearly progress reports of the National Health Plan are opened for public feedback in an online portal (eelnoud.valitsus.ee) – an excellent example of how public participation can be organized. Another good practice of the National Health Plan is that regular overviews of activities are conducted and clear indicators, baselines and targets related to risk factors and health outcomes are set, monitored on a yearly basis and reviewed every four years. Having such data may facilitate communication with other sectors. An evaluation of National Health Plan implementation (2009–2015) is also planned.

Lack of human and financial resources is still a challenge for implementing the National Health Plan. Lack of high-level awareness and political will on health in all policies is also a challenge for collaboration between sectors. The fact that the National Health Plan is mandated by legislation was highlighted as a facilitating factor. The intersectoral Steering Committee offers a forum for discussing issues of common interest and operates within clearly set, measurable targets. Since its activities are also open for public review, it is a good example of a national-level intersectoral body, which is accountable, transparent and has the potential to foster ownership of intersectoral action across sectors, including civil society.

74 France – National multiannual roadmap tackling poverty and social exclusion 2013


To respond to the recent increase of poverty and social exclusion in France among groups in vulnerable situations (especially children, young people and single parents), an assessment was organized to identify and tackle the causes of poverty. The result of this exercise was an interministerial committee adopting a National Multiannual Roadmap to tackle poverty and social exclusion in 2013.

The plan includes a new approach to poverty based on five principles: objectivity, non-stigmatization, participation of the poor, fair rights and an intersectoral approach. Three axes define its main focus: prevention, assistance and support to those who need help, and participation of the poor with greater coherence between public policies at the national and subnational levels. This approach is applied to six different public policy areas: access to social rights and minimum benefits; jobs, work and vocational training; families and children; housing and shelter; health and access to health care; and access to banking services and fighting excessive indebtedness.
The General Inspectorate of Social Affairs is responsible for implementing and revising the plan and counts on the support and leadership of the prime minister. The first phase of implementation has been completed and reviewed. The tools used for implementation at the national level include regular interministerial meetings organized by the Directorate-General for Social Cohesion and multistakeholder discussions that also involved participation of the National Council on Policies for Combating Poverty and Social Exclusion (Conseil national des politiques de lutte contre la pauvreté et l’exclusion sociale). Similar meetings are also organized at the subnational level by government services. Reports on the regional developments are regularly requested at the national level.

75 Ireland – Healthy Ireland

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

In 2012, Ireland adopted Healthy Ireland, a framework to improve the health and well-being in the country for the period 2013–2025. Several intersectoral mechanisms were established at a high level involving regular meetings with representatives across key government departments. The Cabinet Committee on Social Policy oversees the implementation of the framework at the government level.

The Healthy Ireland framework for improved health and well-being, 2013–2025 is a strategy based on the determinants of health. Inspired by Health 2020, it has four central goals:

- increasing the proportion of people in Ireland who are healthy at all stages of life;
- reducing health inequalities;
- protecting the public from threats to health and well-being; and
- creating an environment in which every sector of society can play its part in achieving a healthy Ireland.

Healthy Ireland sets out a framework of 64 actions for public and private sector organizations, communities and individuals across six themes:

- governance and policy;
- partnerships and cross-sectoral working;
- empowering people and communities;
- health and health reform;
- research and evidence; and
- monitoring, reporting and evaluation.

Although it might sound trivial, a photograph of every minister with a copy of the framework convinced all stakeholders that intersectoral commitment was present from the outset and ensured wide-scale commitment to implementation across all the other relevant sectors.
The implementation of Healthy Ireland has been ongoing for three years, and the lesson is that it is not easy to do but is achievable. Four key challenges to implementation have been:

(1) measurement – better methods of measuring the success of policies needs to be developed; although better working relationships have been developed with other government departments and stakeholders, measuring the overall success of the policies is difficult, especially at such an early stage;

(2) responsiveness – the European Region is changing rapidly, and policies must be able to adapt with it;

(3) budgets – financial mechanisms to effectively share budgets between sectors must be identified; and

(4) people – a shared understanding must be developed between stakeholders that, although they might be described differently, there are mutually beneficial outcomes between stakeholders and building the right relationships with the people in other organizations can help to develop mutually acceptable approaches and can assist in knowing whether engagement is taking place with the right stakeholders to achieve maximum impact and efficiency.

76 Ireland – National Children’s Strategy


This case study examines the development and use of a set of children’s well-being indicators within the National Children’s Strategy. The strategy was published in 2000 as an initiative of the United Nations Convention on the Rights of the Child, proposing a 10-year action plan that would move the country towards a state of greater respect for children and their voice and contribution to society and support them in pursuing their right to enjoy safe, full childhoods. Collaboration between professionals and young people was fundamental to the plan, ensuring that the project was child-centred, equitable and inclusive.

The National Children’s Office was established to lead implementation, a key part of which was the formation of the National Children’s Parliament, a forum in which children can debate issues that concern them. A Children’s Ombudsman was appointed to liaise with children and promote their welfare and rights by addressing complaints raised. The ombudsman publishes an annual report.

The dominant theme of the strategy is better understanding of children’s lives and experiences. Child well-being indicators were established to progress this theme through two empirical studies. The first saw children being given tasks to identify what they viewed as important in ensuring they were well and stayed well, with an overall schemata being formed after the study had undergone several phases with different groups of children. The second involved a group of key informants made up of parents, policy-makers, researchers and service providers who collaborated to determine a final set of indicators from those the children of the first study had identified. The final set of indicators was then divided into six domains: sociodemographic; children’s relationships; education outcomes; health outcomes;
social, emotional and behavioural outcomes; and formal and informal support. This initial report therefore set a benchmark for the development of children’s well-being and development in Ireland.

Three subsequent reports have been released, allowing trends to be observed. Progress reports in 2002, 2003, 2004 and 2005 indicated substantial progression in the three main goals identified in the initial report, with all intended activities addressed by 2005.

Proof of the success of this intervention can be deduced from the presence of the child well-being indicators, which are publicly available for use in monitoring, describing and evaluating the state of children in Ireland. The state of the nation’s children report series also helped to identify specific issues within children’s lives, such as binge drinking. Findings such as this have in turn facilitated national consultations with young people about alcohol misuse – a problem that may have gone unnoticed in the absence of regular publication of new data.

77 Israel – Healthy Israel 2020


In Israel, the Healthy Israel 2020 initiative is a whole-of-government process for defining Israel’s policy on disease prevention and health promotion. Led by the Ministry of Health, it establishes intersectoral targets and strategies to improve the health of the population and reduce health disparities, drawing on Health 2020 objectives and priorities.

78 Israel – A round table of national programmes working at the local level


The Israel Healthy Cities Network identified that several sectors were implementing national initiatives at the local level that had had health promotion benefits to them. For example, the Ministry of Defense has initiatives on non-violent cities and on alcohol and drug abuse. The Ministry of Welfare, together with some other ministries, have a programme on children and youth at high risk. They then started to attempt to engage with different sectors and bring them together to pool the health promotion potential of these separate initiatives.

The process of engaging and bringing people together started in 2014 with a national network learning meeting, where seven initiatives were invited to present their goals and activities. The participants agreed to continue to meet and find ways to work together. The Israel Healthy Cities Network invited all leading representatives to a round-table discussion. This took more than two years of theoretical and practical discussions, including a pilot study in four network cities in which several other initiatives were operated in parallel. In the pilot cities, it culminated in a combined steering committee, where local-level common health goals were identified and common projects and initiatives were shared. The identification of common goals that are beneficial for health ensured that projects and initiatives from different sectors complemented each other and contributed to achieving these common health goals. This provided a platform to collaborate on projects, and now collaboration between sectors and sharing experience of different programmes is much more natural, since relationships have been built over time.
A key concern for sectors was that they would lose their initiative if they brought it to a shared committee. The Steering Committee, chaired by the health sector (Israel Healthy Cities Network) made sure they would not assimilate any ideas, allowing everybody to work individually but towards common goals at the local level.

The challenges faced were:

- to build trust between all the partners;
- each partner has its own system of data collection and reporting – no one wanted to lose control of that or to change it; and
- agreement not to add new structures or committees to the cities.

These challenges were overcome by the following.

- Trust was built by having several discussions to learn to know each other (10 meetings of two hours each) and by carrying out the pilot project in the four cities.
- We decided not to change the system but to share information in each relevant city.
- We decided to invite each other to present initiatives in training courses to expose city coordinators of each initiative to all other initiatives.
- Every network city was advised to include in their steering committees all representatives of the initiatives working in their city (non-violent cities, anti-alcohol and drug abuse, children and youth at high risk, the programme for preventing child injury (NGO), health promotion of infants and young children (NGO), the suicide prevention programme, sustainable development, etc.). Most cities implement that advice.
- Every initiative has a steering committee at the local level. All agreed to invite representatives of all the other initiatives.

79 Iceland – Establishment of a Ministerial Council on Public Health: a public health milestone


Iceland faces demographic changes and other major challenges, calling for effective solutions to preserve and improve health and well-being at all stages of life. One priority of the current coalition government’s (2013–2017) platform is to ensure equality for all citizens by means of public health and preventive measures. In 2014, the Prime Minister of Iceland established, with the approval of the government, the Ministerial Council on Public Health. The main role of the Council is to promote dialogue and cooperation between ministers and ministries, to harmonize overlapping thematic areas and to prepare a comprehensive public health policy and action plan for submission to the government.

Through intersectoral work, the Council aims to improve health, well-being and equity at all stages of life with special emphasis on children and adolescents. To reach these goals, a comprehensive public health policy and action plan will be published in 2016. One action in the plan’s draft is implementing a health-promoting municipality project in all municipalities in Iceland. This project will assist municipalities at the local level to work across sectors to
create environments that promote the health and well-being of all inhabitants, emphasizing health in all policies.

Participatory mechanisms have brought together stakeholders from various sectors through the work of the Ministerial Council and the Public Health Committee, thereby facilitating communication, joint understanding and a sense of ownership among those involved; all stakeholders in the Public Health Committee were invited to contribute to the draft strategy. The Ministerial Council on Public Health has earmarked funding from the state budget for the health-promoting municipality project in 2016. An evaluation plan is included in the public health strategy, and some suggested actions are being assessed.

The establishment of the Ministerial Council is an important milestone for public health work in Iceland, bringing together ministers from different sectors to find common ground to work towards improved health, well-being and equity.

80 Montenegro – Whole-of-government action for health


In April 2014, the Ministry of Sustainable Development and the Ministry of Health agreed to tackle social determinants of health and to reduce the prevalence of noncommunicable diseases within the new national sustainable development strategy.

The Ministry of Sustainable Development is the government ministry with responsibility for developing and reviewing intersectoral policies and is a major ally in taking a systematic, whole-of-government approach to address determinants of health and equity, specifically as these relate to preventing and controlling noncommunicable diseases.

Evidence and examples from Health 2020 were used to support dialogue and build strong alliances for action between the two ministries and across the government. The focus for implementation is framed around the importance of improving health and reducing inequities for achieving national goals for inclusive sustainable development.

81 Montenegro – Social and child protection law

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

On 16 July 2015, the Parliament of Montenegro adopted the Law Amending the Law on Social and Child Protection. The amendments to the Law introduce an allowance for a parent or a guardian – care of a person who is a personal disability allowance beneficiary and a child allowance paid for parents with three or more children. From January 2016, working mothers with three or more children who have 25 or 15 years of service will, if they wish, receive a lifetime monthly benefit comprising 70% of the average net salary in Montenegro earned in the year preceding the year of exercising that right. In addition, unemployed women with three or more children who have been registered at the Montenegrin Employment Agency for at least 15 years can exercise the right to lifelong compensation amounting to 40% of the average net wage in Montenegro.
The Government of Montenegro has recognized the need for an intersectoral approach in preventing child abandonment and relinquishment, as evidenced by the development and signing of the Protocol on Intersectoral Cooperation for the Prevention of Child Abandonment/Relinquishment (henceforth the Protocol) by three ministries: the Ministry of Labour and Social Welfare, the Ministry of Health and the Ministry of Education. The Protocol represents an expression of commitment made by respective ministries to undertake all the necessary measures to prevent institutionalization, to engage in transforming existing institutions and to improve the quality of services and programmes for children.

Montenegro has been using an intersectoral approach to cases of violence against children, as reflected by the work of the local-level operational multidisciplinary teams for protecting children from violence, abuse and neglect. Representatives and professionals from different sectors are working together at the local level to tackle the issue.

In relation to the development of social and child protection services at the local level, the establishment of a network of childcare centres at the local level is very important for improving the situation of children with disabilities. So far, 111 childcare centres have been founded in Montenegro. This form of protection of children promotes the realization of the rights of children with disabilities, especially children with intellectual disabilities, and their socialization and inclusion in the community. Creating a network of childcare centres in all municipalities throughout Montenegro is a key aspect of social welfare reform in Montenegro.

82 Norway – National system for follow-up of public health policies – a common intersectoral reporting system


Norway has a long history of developing and implementing intersectoral action for health at different levels of governance. A wide array of tools and mechanisms has been developed to support these efforts. This case story discusses Norway’s national system for following up public health policies and the common intersectoral reporting system, with a focus on the intersectoral indicators developed to support this work. These systems derive their mandate from government white papers.

White Paper No. 20 (2006–2007), National strategy to reduce social inequalities in health, highlighted public health policy as an intersectoral issue and first launched the intersectoral reporting system. White Paper No. 34 (2012–2013), Good health, a common responsibility, reinforced the need for collective action on health and established a national system for following up public health policies.

The main strategic goal is to improve public health and to reduce social inequalities in health. To support this work, various sectors have collaborated to create indicators across sectors to feed back to policy development. For the indicators, data are disaggregated according to such parameters as socioeconomic variables and sex. They are also produced for vulnerable groups. An interministerial committee with representatives from 12 ministries has worked on developing these common indicators, and intersectoral teams have separately worked on creating indicators for specific topics such as economic living conditions, social support, safe and health-promoting environments, health-related behaviour, early-life living conditions, the working environment and inclusion and local public health work.
Collaboration to create the common reporting system and to develop common indicators has been challenging at times. Getting accurate data is challenging. Not all sectors routinely collect data, or they have not collected data on socioeconomic variables. The perception of challenges also varies from one sector to another, since each sector has different societal goals. In many intersectoral projects and programmes, the health sector has partly a history of pushing a ready-made prescription of solutions to other sectors, when the right approach should be negotiated. The determinants of health approach and reporting system seem to nurture collaboration. In developing the national system for following up public health policies, other sectors have been involved from the beginning. Sectors have commonly decided on the indicators to use in this work. Having data on health-related inequalities, rather than traditional health data, makes it easier to approach decision-makers in different sectors. Ensuring that other sectors participate in creating this data will also ensure ownership. Other factors that have facilitated this work include high-level political commitment and building the capacity of the health sector in negotiation, understanding power, processes and policy development.

This experience demonstrates how intersectoral action on health equality can be supported by developing common indicators and, more broadly, through joint reporting and follow-up systems.

83 Sweden – Promoting social sustainability through intersectoral action at the local and regional levels


In Sweden, social sustainability has been promoted through intersectoral action at the local and regional levels. In 2011, at the request of some municipalities and regions, the Swedish Association of Local Authorities and Regions initiated an intersectoral project on joint action for social sustainability – reducing inequalities in health 2011–2013. The work was initiated as a response to health inequality problems that were evident at the local and regional levels. The project was started as a joint local and regional effort, acknowledging the fact that facing these problems will require the efforts of multiple sectors. As a result of this initiative, the Swedish Association of Local Authorities and Regions, in collaboration with the Public Health Agency of Sweden, established an intersectoral Social Sustainability Forum in 2014, which aims to promote welfare in a socially sustainable way and includes 16 representatives from the local and regional authorities, state authorities, the private sector and civil society.

The Forum aims to promote welfare in a socially sustainable way by providing for the basic needs of all people, by guaranteeing human rights in practice and contributing to including all people. More specifically, it aims to strengthen knowledge about how to implement social sustainability issues in regular governance and management systems and pursue successful strategic cooperation within and between the public sector and nongovernmental organisations, the business sector and the research community.

The joint action initiative and the Social Sustainability Forum are great examples of local and regional intersectoral action, and many key lessons have been learned from this experience that may benefit local, municipal and national level decision-makers and other actors in other countries. First, the use of “social sustainability” instead of “public health” has been
innovative. Terms and goals such as “reducing the health gap” are not always understood by or appealing to other sectors, and in Sweden, social sustainability language worked better with other sectors than typical public health language. Another lesson learned is that clear short-term and long-term goals should be set. At the local level, the focus of action should be on what can be changed – in other words, issues that are the responsibility of the local governments. The fact that some sectors have national-level policy goals, whereas others may set their goals at the local level, can complicate intersectoral work. Priorities should also be set for action, and importantly, economic impact needs to be demonstrated to policy-makers. The costs of the actual intersectoral action should be carefully planned, and this should be considered in setting priorities. The sustainability and ownership of intersectoral action was deemed good in this case, because it was initiated from the bottom to the top: some municipalities and regions asked the Swedish Association of Local Authorities and Regions to take a national lead in coordinating support for local-level intersectoral action. The local stakeholders benefit from the support they receive from the Swedish Association of Local Authorities and Regions and the Public Health Agency of Sweden.

84 Turkey – National strategic plan for 2013–2017


Turkey’s national strategic plan for 2013–2017 is strongly aligned with the values and principles of Health 2020, and Turkey is now implementing a national Health 2020 vision in collaboration with the WHO Regional Office for Europe through a combination of health system strengthening, action on social determinants of health and improved intersectoral governance for health.

85 Turkey – Health Transformation Program


The Turkey Health Transformation Program, which has been developed based on theoretical knowledge available in the literature and up-to-date case examples from various countries, has been concluded in just eight years – a very short time period – and has proved to be a good example of knowledge, competence and experience with its successful outcomes. The Health Transformation Program aimed at improving the governance, efficiency and quality of Turkey’s health sector, and the continued successful implementation of this major reform programme depends on tracking its impact on health outcomes, outputs and structures. The Ministry of Health has identified further monitoring and evaluation capacity-building as a critical issue for phase I of the Health Transformation Program. This has become even more important following the development of the Ministry of Health Strategic Plan for 2010–2014. This effort is part of ongoing reform of the public sector in Turkey that requires all sectors to establish five-year and annual strategic plans and budgets.
The Act is the first legislation of its kind: legislation for sustainable development in response to the 2030 Agenda for Sustainable Development and the Sustainable Development Goals. It is umbrella legislation covering other acts such as the Public Health Bill 2016; Environment (Wales) Act 2016; and Social Services and Well-being (Wales) Act 2014.

The Act is intended to improve the social, economic, environmental and cultural well-being of Wales. It attempts to make the public bodies listed in the Act think more about the long term, work better with people and communities and each other, seek to prevent problems and take a more joined-up approach.

This new law will mean that, for the first time, public bodies listed in the Act must do what they do in a sustainable way and that public bodies need to make sure that when making their decisions they consider the potential effects they could have on people living their lives in Wales in the future. The public bodies listed in the act are: Welsh ministers; local authorities; local health boards; Public Health Wales NHS Trust; Velindre NHS Trust; national park authorities; fire and rescue authorities; Natural Resources Wales; the Higher Education Funding Council for Wales; the Arts Council of Wales; the Sports Council of Wales; the National Library of Wales; and the National Museum of Wales.

The Act expects them to:

- work together better;
- involve people reflecting the diversity of communities;
- look to the long term as well as focusing on now; and
- take action to try and stop problems getting worse – or even stop them from happening in the first place.

The Act establishes a statutory Future Generations Commissioner for Wales, whose role is to act as a guardian for the interests of future generations in Wales and to support the public bodies listed in the Act to work towards achieving the well-being goals.

The Act also establishes public services boards for each local authority area in Wales. Each public services board must improve the economic, social, environmental and cultural well-being of its area by working to achieve the well-being goals.
87 Various countries – Multisectoral strategies to tackle noncommunicable diseases


Several countries have applied the Health 2020 framework to developing national multisectoral strategies for preventing and controlling noncommunicable diseases. Azerbaijan, Bulgaria, Kyrgyzstan and Tajikistan have all recently developed noncommunicable disease strategies based on the principles of Health 2020. Georgia and Turkmenistan are developing national noncommunicable disease strategies that reflect the principles and priorities of Health 2020 with the support of the Regional Office. Turkmenistan has agreed to set up a multisectoral committee to oversee the strategy. Belarus has expressed interest in hosting a regional meeting in 2015 on a life-course approach in the context of Health 2020.

88 Regional – European Health Information Initiative


European Health Information Initiative

The European Health Information Initiative is a multimember WHO network that is committed to answering questions and improving the health of the people of the European Region by enhancing the information on which policy is based. The vision is an integrated, harmonized health information system for the entire European Region with evidence for policy-makers. This can be achieved by fostering international cooperation to exchange expertise, build capacity and harmonize data collection.

Subtheme: integrated services

89 Armenia – Youth-friendly health services


Youth-friendly health services

Collaboration involving the Ministry of Health, UNICEF, NGOs and professional institutions developed the national concept on youth-friendly health services in 2005 and the subsequent emergence of a national strategy on child and adolescent health. Activities such as staff training using WHO orientation programmes, development of national standards of care and approval of standards in some pilot districts were taken forward.

The national strategy identified a set of aims for the development and surveillance of adolescent health, with implementation beginning with compulsory health status screening of...
girls at 12 years and boys at 15 years, initiated by the Ministry of Health. Nurses were given specific training and adolescent health was introduced to undergraduate and postgraduate health curricula.

Barriers to implementation revolved around time and resources. Screening was considered to offer insufficient analysis in some cases, with a lack of time and training in counselling skills among doctors and nurses leading to inadequate consultations. The vast majority of family doctors are women, which proved a disincentive for boys to seek consultations.

The family setting is not straightforward as a result of socioeconomic inequities and inadequate resources, but the traditional family structure has the potential to offer greater support and better communication than those in other European countries, with high priority being placed on improving communication problems within the home. Armenian families have not yet adapted to adolescents’ needs because the concept of adolescence has only recently been created in the country as a product of the independence era and free-market generation. School therefore still appears to be the key arena for implementing change, since a high proportion of Armenia’s children and adolescents claim to like school.

90 Bosnia and Herzegovina – Integrated health, education and social programmes

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

With the purpose of providing integrated health, education and social programmes for early child development within the system, competent institutions in Bosnia and Herzegovina work on strengthening intersectoral and multidisciplinary approaches for improving child and adolescent health and welfare and reducing health inequities. Since 2003, new principles and standards have been promoted, such as recommending enrolling all children in preschool programmes one year before enrolment in school and increasing the coverage of children with institutional preschool education.

The intersectoral element of this approach is vital, with continual cooperation between sectors throughout the programmes, at all stages from development to implementation. Engagement of the wider social community is also a key element: NGOs and mass media are used to gain social support for the programmes, and groups from the community, such as parents, are also involved in the programmes at different stages. The need to strengthen an integrated approach to early child involvement is seen as crucial, since it is needed to ensure that children are healthy and physically and emotionally ready to be successful and overcome the challenges that life brings.

The programmes aim to move towards focusing on children rather than a traditional sectoral focus, thus allowing for the partnership to be sustained and leading to increased ownership from all sectors, stemming from increased responsibility and accountability for all partners in the programme.
91  Finland – Integrated services for families and children

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

In many municipalities, Finland has integrated services for families and children in family centres. These centres are a single point for several relevant services that focus on providing preventive services and early support for children and families. Although most of the services available come from the social and health sectors as well as early childhood education programmes, experts from other sectors (NGOs, schools, culture and sports) also provide services in the centres. The current government has identified implementing family centres across the country as a key priority, ensuring funding and political will. Similarly to the examples mentioned from France and Ireland, children and families (as the target groups) also actively participated in the decisions taken on developing the programmes and services offered at the family centres and their methods of implementation.

The data required to effectively assess the impact of integrated services on children and families are not always available, especially at the local level. This represents a key issue, and therefore new means of collecting, using and disseminating data are urgently required to pursue an effective transformative agenda.

92  France – Joint health and social sector programmes (1)

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

France has reiterated the importance of early, targeted interventions through policies that are family friendly, gender responsive and without discrimination and stigma. France has initiated joint action between the health and social sectors through a programme based around the mobile child welfare protection service, which has more than 5000 clinics throughout the country. The programme integrates the health sector and social sector approaches, transferring best practice between the sectors to prevent child abuse and promote well-being. The programme has an intersectoral foundation, being adapted from psychologists in North America, and it was decided to adapt it to include home visits from paediatric nurses for health promotion purposes. The programme is comprehensive, including training health professionals, creating guidelines and ensuring home visits for promoting health and well-being among parents.

The results on effectiveness are not yet available, since feedback from both health and social sector professionals and the families involved in the programme is still being gathered. The programme attempted to experiment with combining both the approaches and the resources of the health and social sectors to deliver a transformative solution. The importance of starting health programmes pre-birth and ensuring continuity before (prenatal interview) and after birth is crucial to maximize effectiveness.
93 France – Joint health and social sector programmes (2)

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

In France, children comprise one fifth of the total population and one third of the socioeconomically deprived population. The poverty rate among the children living with only one parent is 36%. In 2013, France took measures within the framework of the National Plan for Combating Poverty and Social Exclusion, which aimed to support parenthood and fight inequalities.

Key measures have been taken to reinitiate access to social housing and to facilitate access to basic services for target populations. This is achieved by providing financial support to poor families with young children, which aims to address geographical inequalities and support families in obtaining access to basic services. Several further actions consider the needs of children, support parenthood and fight inequalities. A change in school schedules and rhythm was implemented in December 2014; the diversification of services welcoming to young children was undertaken; and social protection services provided to children were improved. A key transitional element of the programme design is the act of listening to and considering what the children (as the target group) had to say on the programme design. Effective intersectoral programmes require better engagement with the community to better understand their lives and therefore design services with their needs in mind. This can be done either directly or by mediating with the social sector.

94 Georgia – Integrated social and health services

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

Georgia is starting to implement integrated social and health services. Although the social and health sectors fall under one ministry, the governance structures in place make coordination between the parts of the ministry complex. Once the regional and local levels are added to a particular programme, cooperation and coordination become even more complex. Recent programmes have focused on ensuring that both sectors are involved in developing programmes from the outset, thereby increasing ownership and input from both sides. This is being facilitated by the development of a health information system and a social information system – which will be accessible to both sectors. The data collected will enable evidence-informed programmes to be developed that provide co-benefits for both sectors, increasing the potential for transferring programmes across regions and municipalities.

95 Israel – 360 degrees

Source: Meeting report: preparatory meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region, 11 July 2016. Copenhagen: WHO Regional Office for Europe; forthcoming.

Since 2011, Israel has run 360 Degrees – the National Program for Children and Youth at Risk, which targets early childhood development. The programme is allocated to areas of low
socioeconomic development; at-risk children who experience problems in development and education are identified from data gathered by maternal and child clinics, operated by the Ministry of Health, and the budget for programmes is allocated accordingly. Different programmes exist under the umbrella of 360 Degrees – social, health, and education programmes. The individual clinics decide the programmes they identify as most likely to be effective for their local context, in accordance with their budget. The maternal and child clinics have been identified as the most appropriate place to deliver the health-related programmes, since they are the first setting for making contact with all children. The integrated nature of the services offered by the clinics means that service users can access social workers and educational professionals at the same setting.

96 Malta – Health system resilience


Health systems need to be resilient to face a changing global economy, especially in response to human and economic crises. Health system resiliency is important particularly in small countries. Malta has created a system-level approach to challenges small countries face in having human resources available and to better prepare for global economic or human crises. The focus is on developing, retaining and training a health workforce. Malta has increased the number of physicians through intersectoral action and international partnerships.

This example shows the importance of addressing resilience at the system level. The interaction of many factors enabled Malta to make progress in reducing the vulnerability of its health workforce and therefore improving the overall resilience of its health system. First and foremost, the adaptive capacity and ability of Malta’s social, educational and health systems to address multiple challenges and opportunities in a rapidly changing national, European and global context has improved.

Subtheme: mental health

97 Regional and global – WHO Thinking Healthy – a manual for the psychological management of perinatal depression


The WHO Thinking Healthy manual is a supplement to the WHO Mental Health Gap Action Programme intervention guide. The intervention guide was developed for use in non-specialized healthcare settings. It includes guidance on evidence-informed interventions to identify and manage several priority mental health conditions. One of the priority conditions is depression in the perinatal period. The intervention guide describes in detail what to do but does not describe how to do it. Training materials have been developed on how to use the intervention guide. The purpose of the Thinking Healthy manual is to provide detailed instructions on how to implement the evidence-informed guidelines contained in the intervention guide for the management of perinatal depression.
Subtheme: health literacy

98  Netherlands – Alliance for Health Literacy


In the Netherlands, combining efforts for empowering individuals or communities with improving health sector communication yields the best results in improving health literacy.

Tackling health literacy in the Netherlands is based on a strong lobby for patients’ rights, which resulted in clear legislation as well as longstanding programmes for improved communication in the health-care sector. The National Literacy Programme, which focuses on general literacy, facilitates intersectoral collaboration in adult education and the empowerment of people with limited literacy.

The National Alliance for Health Literacy was created in 2010 and has now more than 60 member organizations, including patients, providers, health institutions, health insurance providers, academe, industry and the business community. The aim of the Alliance is to advocate for incorporating health literacy into the daily operations of health institutions, to share knowledge and experience and to plan joint action. The Alliance has a web site with information and organizes regular meetings and workshops. The Alliance supports organizations for empowering individuals and communities.

Health literacy approach in the Netherlands

Patient groups are well organized in the Netherlands, and their umbrella organizations provide a strong political lobby. At the institutional level – such as hospitals – patient councils negotiate with management for patient-friendly measures. Patients’ rights are laid down in legislation on informed consent, which obligates health-care providers to provide proper understandable information and to get the patient’s approval before treatment. In 2011, the National Health Council produced advice for the Minister of Health on tackling limited literacy in the health sector. This will further strengthen the position of vulnerable patients and their legal rights with regard to informed consent.

The Netherlands has a decades-long tradition of special health communication for migrants and minority groups, often in foreign languages, using information materials and involving mediators, interpreters and trainers. Based on research into inequities in health, the health communication programmes were broadened to people with limited literacy to ensure that these groups could access health services adequately.

Health-care institutions, hospitals, home care organizations and health insurance providers are revising their health information on web sites, in brochures, in folders and on signs in buildings. They get support from specialized communication experts, who work closely with people with limited literacy. Smart solutions, such as prepackaged medication, remote sensors, tablet PCs, phone text messages with appointment reminders and interactive web sites, are applied to simplify complicated health interventions or guide people through administrative procedures. Sensitizing and building the capacity of health workers is an important part of the work, and their professional organizations support this.
Subtheme: nutrition, obesity and physical activity

99 France – National Nutrition and Health Programme


Concerns have been raised in France, as in many affluent countries, about health problems related to poor nutrition and lack of physical activity among children and young people.

A dual action plan was implemented as part of the National Nutrition and Health Programme to decrease obesity prevalence among young people.

Nutritional prevention measures were set up for the whole population and specific subgroups, and screening of children for nutritional problems and obesity management during school medical examinations was improved. A multidisciplinary obesity management approach was recommended with the cooperation of medical and non-medical professionals.

The first National Nutrition and Health Programme was implemented in January 2001, with the overall objective of improving the health of the general population through action on nutrition as a major determinant. Within this, nine quantified priority objectives relating to food consumption, physical activity and biological and anthropometric indicators were established.

The Ministry of Health promoted these within the public and private sectors through training, research and monitoring. The Programme’s main objectives were to halt the increasing prevalence of obesity among young people and improve children’s and adolescents’ calcium and vitamin D status and infants’ iron status.

A national food guide based on the objectives of the National Nutrition and Health Programme was created in 2002, initially aimed at the general population but later adapted for parents, health professionals and adolescents. This strategy enabled adolescents to base their nutritional intake on personal preferences and enjoyment of food while highlighting the significance of their eating choices.

A logo was created for all signature campaigns, but nongovernmental bodies could also apply to use it. The logo has subsequently been used to validate several nutrition education tools from associations and catering companies based on scientific and educational criteria, but few initiatives target collective responsibility in such areas as food supply and changes in the environment. The National Nutrition and Health Programme for 2006–2010 aspired to implement action in these areas.

School is an important setting for implementation and a key influencing factor, but adolescents spend limited time there. Evidence for approaches outside the school setting is still being accumulated, but implementing nutrition-based goals within alternative settings such as family and leisure environments may have greater effects on diet and physical activity levels.
Subtheme: child protection

100  Ireland – A school-based sexual abuse awareness programme


In Ireland, teachers provide the Stay Safe education programme to primary school children aged 5–12 years. The curriculum uses activities such as class discussion, role play and video and audio tapes to educate children about feelings of safety, bullying, wanted and unwanted touch, disclosure of inappropriate interactions and dealing with strangers. Programmes may also include components for parents and guardians focused on dealing with disclosure and discussing topics such as sexual abuse with children at home. Children who participated in the Stay Safe programme showed significant improvements in safety knowledge and skills at three-month follow-up.

Subtheme: social cohesion

101  Poland – Tackling three types of exclusion: structural, physical and normative


Poland has attempted to tackle three kinds of exclusion – structural (caused by education, income and place of living), physical (health- or disability-related) and normative (related to alcohol and substance abuse and delinquency). Current approaches for levelling educational opportunities for those with chronic illnesses were comprehensively reformed in 1999, with the goals of strengthening the position of teachers, establishing a common preschool curriculum, lowering compulsory education to age six years and implementing a reform programme of at every stage of education. Educationalists and psychologists working with teachers were enabled to broaden their knowledge, allowing teachers to offer students psychological and pedagogical support, and the “safe and friendly school” government programme produced handbooks outlining the educational needs of individuals with specific illnesses.

The requirement to overcome prejudices and stereotypes was identified as a priority but has proved difficult to translate from the national to the local level.

NGOs ran campaigns to prevent social exclusion as a result of poverty, lack of parental care or chronic diseases, typically collecting funds for treatment and rehabilitation of children with specific needs. Foundations are most likely to care for children in difficult living conditions, but care can only be provided when family members report the need. Media campaigns have been employed to spread awareness, with text messages, billboards, web pages, social media
sites, posters, leaflets, television, stamps, Internet radio, newspapers and cinema advertising being used to support the inclusion of sick and disabled children.

These interventions faced several barriers, primarily parental attitudes. Parents were generally reluctant to include children with special education needs in mainstream classes because of fear of consequently lowering teaching and education levels. NGOs, which depend almost entirely on external funding, found public administration frequently hindering their daily operations through excessive bureaucracy, although the development of memorable slogans and recruitment of celebrities to deliver them have raised the profile of campaigns and increased financial support. Expanding the scope and activity of NGOs and local initiatives is seen as part of the process of constructing civil society.
The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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