BACKGROUND PAPER

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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Acronyms

HiAP health in all policies
OECD Organisation for Economic Co-operation and Development
SDG Sustainable Development Goal
UNDP United Nations Development Programme
UNESCO United Nations Education Scientific and Cultural Organization
UNICEF United Nations Children’s Fund
Executive summary

This Background Paper was produced to support and inform the discussion at the high-level conference on Working Together for Better Health and Well-being: Promoting Intersectoral and Interagency Action for Health and Well-being in the WHO European Region, held in Paris, France on 7–8 December 2016.

As established in the United Nations 2030 Agenda for Sustainable Development and Health 2020, the European policy and strategy framework for health and well-being, sustainable change requires a focus on inter- and intragenerational development. The 2030 Agenda emphasizes the importance of leaving no one behind – a vision that cannot be achieved without creating societies that are healthier and more equitable. It also reinforces the values and principles of Health 2020, with its focus on enhancing policy coherence, supporting intersectoral action and strengthening partnerships.

Intersectoral action for health also provides an opportunity for the WHO European Region to develop transformative partnerships for health, building on existing global, regional and national commitments to health and well-being. Coordinating actions across sectors requires new approaches to health governance that are inclusive, participatory and equity-focused, such as whole-of-government, whole-of-society, and health-in-all-policies (HiAP) approaches. This includes, for example, bringing children and adolescents, their families and communities into the decision-making process through participatory approaches, as well as taking a gender-transformative approach to interventions.

The relationship between health and well-being, inequalities, social protection, education and governance is also captured in the Sustainable Development Goals (SDGs) related to poverty (SDG 1, no poverty; and SDG 2, no hunger), health (SDG 3, good health and well-being) education (SDG 4, quality education), gender (SDG 5, gender equality), water and sanitation (SDG 6, clean water and sanitation), employment (SDG 8, decent work and economic growth), inequality (SDG 10, reduced inequalities) and partnerships (SDG 17, partnerships for the goals).

This background paper is not an exhaustive review of the social determinants of health, but touches on a number of key areas addressed in the high-level conference in Paris. It is supported by three thematic papers which have been produced in tandem and address the main themes of the conference:

- thematic paper 1: universal social protection floors for better health and well-being for all children and adolescents;
- thematic paper 2: schools and pre-schools promoting health and well-being for all children and adolescents; and
- thematic paper 3: good governance for the health and well-being of all children and adolescents.
**Introduction**

Ensuring a sustainable and healthy future for children and adolescents is essential for the sustainable development of the WHO European Region. This requires a renewed focus on children and adolescents, their families and communities: investment in people and human capital, as well as the environments that sustain them, is at the heart of achieving health and well-being.

Acting on the root causes of poor health and well-being in childhood and adolescence can improve health across the life-course. The health and well-being of all young people, both in childhood and in later life, and that of future generations is affected by various determinants – social, economic, environmental, political, cultural and commercial. Many of these extend beyond the health sector, affecting children’s social, emotional and cognitive development and the home and community environments in which they grow, play and learn. Successfully addressing health determinants and issues of health equity in childhood and adolescence means working across sectors to build synergies, partnerships and coherence across policies and interventions.

Investing in all children early in their development, and addressing inequalities early so they do not continue and perpetuate throughout generations, provides the greatest return on investment at any point during the life-course. Healthy childhood generates dividends for health and well-being, and the earlier the investment during the life-course, the greater the benefits. Currently, inequalities among children exist between and within countries in the Region: disregarding these inequalities fosters their perpetuation, contributes to diminished social cohesion, and puts societies at risk of societal and political instability. Inequality gaps cannot be ignored in the quest to achieve sustainable development and a healthy and equitable society for future generations.

By ensuring that all children at risk of vulnerability gain the most from policies and interventions, intersectoral action for health can help to alleviate inequalities throughout the life-course. Addressing the wider determinants of health can strengthen health systems by mitigating the burden placed on them and promoting so-called virtuous cycles, in which good health is promoted by, but also promotes, the environments in which children and adolescents, their families and communities live, learn, work and play.

Tackling inequalities has been central to the improvement of health and well-being for the Region throughout the implementation of Health 2020, the European policy framework supporting action across government and society for health and well-being (1), and has been given particular prominence since the publication of the review of social determinants and the health divide in the WHO European Region (hereafter referred to as the Review) (2). The United Nations Development Programme (UNDP) dialogue on inequities (3) and the prominent placing of inequalities at the heart of the 2016 UNDP regional human development report (4) have ensured that the tackling of inequalities is at the heart and forefront of the conversation surrounding health and well-being, and the sustainable future of the Region.
Act together with the health, education and social sectors

A good start in life generates significant dividends for health and well-being (5). While a number of determinants affect child and adolescent health and well-being, the education and social sectors play a particularly important role. Addressing these determinants across sectors can lead to transformative changes in the health and well-being of children and adolescents that carry on throughout the life-course. Educational settings – ranging from child care and pre-schools in early years to school during adolescence – promote cognitive, emotional and executive function, and social development and skills acquisition, as well as encouraging sustained participation in activities that build individual resilience. In the social sector, household income (from employment and social transfers, such as child benefit) remains the strongest determinant of child health and well-being (6). Access to social services, including quality affordable child care and child protection services, and health services is key to preventing families from experiencing in-work poverty and promoting the health and development of children and adolescents. Acting on the social determinants of health, together with the economic, environmental and commercial determinants, has the potential to reduce health inequalities. Children at risk of vulnerability often face multiple disadvantages and have the most to gain from transformative changes across the social gradient.

Act with urgency to improve health equity and the social determinants of health

Reducing health inequalities and addressing the social determinants of health is critical to enhancing the health and well-being of our young and future generations. The proportion of countries in the Region with a standalone policy on addressing health inequities or the social determinants of health increased from 58% in 2010 to 67% in 2013 (6). National policies to address health inequities and social exclusion have sharpened their focus on the root causes of poor health, including an emphasis on tackling poverty, improving the physical environment and enhancing human rights (7).

More can be done by working together in partnership with local and regional authorities, civil society, academia, the media and the private sector across all sectors, starting with the health, education and social sectors. The Review (2) highlights that inequalities are often perpetuated from one generation to the next. Child poverty, for instance, is a persistent problem across the Region at national and regional levels. Despite 10–15 years of economic growth in eastern Europe before the financial crisis, child poverty has not improved (8). Child poverty rates vary dramatically across western Europe, despite higher levels of spending, ranging from 12% to 36% in 2014 (9). The main factors affecting child poverty include household composition, families’ labour market situation and parents’ level of education (9).

This is supported by work under the framework of UNDP’s eastern Europe and central Asia 2015 and 2016 Istanbul development dialogues (a platform for research, advocacy and partnerships) (3), which were devoted to inequalities. The 2016 UNDP regional human development report (4) finds that despite relatively equal distributions of income, broad access to social services and small gender disparities, many countries in the Region are facing growing threats to their human development accomplishments – and the threats are greatest in health. The report presents new evidence on the determinants of noncommunicable diseases, HIV and self-
assessed health and how dimensions of inequity modify individual and collective exposure to
determinants of health and health outcomes, and proposes programming priorities to respond to
these challenges more effectively.

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**Box 1: Case Examples**

*Example 1:* In response to the global crisis, the government of Iceland set up Welfare
Watch, a system to monitor and respond to social and financial effects felt by families and
individuals. The programme focuses on at-risk populations such as children, young families,
people with disabilities, those with long-term illnesses and older people.

*Example 2:* After conducting surveillance on overweight and obesity, Cyprus developed a
national nutrition plan in 2008 to prevent noncommunicable and communicable diseases in
children and adults. It addresses the issue of overweight and obesity at all life stages. Cyprus
has also used this strategy to develop a programme for its migrant population.

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**Start early, act on time and act in regional partnership to implement
the life-course approach**

A healthy childhood generates dividends for health and well-being, and the earlier the
investment during the life-course, the greater the benefits (10). This is also a central tenet of the
Lancet Commission on Early Childhood Development (1,11,12). A life-course approach
recognizes the ways in which past experiences and the many determinants of health – political,
cultural, social, economic, environmental and commercial, among others – affect the health
status of young children, adolescents, adults and older people over time (13). As stated in the
Minsk Declaration (adopted at the 66th session of the WHO Regional Committee for Europe in
September 2016), a life-course approach to health and well-being is best served by “acting early,
acting on time, and acting together” (13). Adopting a life-course approach is one of the four
guiding principles of Investing in children: the European child and adolescent health strategy
2015–2020 (14). It is critical that evidence-informed interventions occur as early in the life-
course as possible and are sustained as needed throughout childhood and adolescence.

The Review emphasizes that ensuring a good start in life for our young and future generations
requires a focus not only on children, but also on the health and well-being of their caregivers
and families (2). This is reinforced by the Lancet Commission on Early Childhood Development,
which promotes the concept of nurturing care and calls for policies that provide caregivers with
the necessary resources to build an environment conducive to child development (1,11).
Enhancing social protection policies and programmes that support parents in balancing the
demands of work and family, for example, has proven benefits for children and can promote
gender equality (2). Interventions inside and outside the health sector can help to achieve this
through, for instance, high-quality health-care provision, access to sexual and reproductive
health services, adequate parental and sick leave, decent working conditions, flexible (but not
less secure) employment contracts and quality child care that is affordable.
The 2016 UNDP regional human development report (4) recommends further strengthening of policy links between labour markets and social protection. While poorly designed social policies can reduce incentives for labour market participation and hiring, this is not a justification for reducing social protection spending and coverage. Instead, wherever possible, the taxation of labour to fund social benefits needs to be supplemented by other funding sources. These may include: higher taxes on environmentally unsustainable activities; reductions in budget subsidies that accrue to wealthy people, or which support environmentally unsustainable activities; more aggressive measures to reduce illicit financial flows, and with them the diversion of budget revenues to tax havens; and more robust direction of budgetary procurement and contracting resources to companies that explicitly promote social inclusion (such as social enterprises). National social protection floors can be good platforms for addressing these issues.

**Improve the health of all families and create empowered and resilient communities**

People’s opportunities for a healthy life and future are closely linked to the conditions in which they are born, grow, work and age (15). Family and community contexts therefore influence the development of a child or young person’s capabilities and traits: some families are in a better position to be more nurturing than others, some communities are safer than others, and some political systems are more supportive of health and social conditions that promote health than others. Empowered and resilient communities respond proactively to new or adverse situations, prepare for economic, social and environmental change and cope better with crisis and hardship (16,17). Community resilience is often defined at three interconnected levels: individual; community; and national or systems level. Good mental health and well-being provide a foundation for individual resilience, strengthen hope for the future, and build the capacity to adapt to change and cope with adversity (18).

Improving communities’ resilience enables individuals and families to be empowered, allowing them to take ownership as partners in the co-creation of their own health and well-being (19,20). This includes community-based support, such as integrated health and social protection programmes delivered in community and education settings that engage parents and caregivers, simultaneously optimizing their health, increasing their health literacy and enabling them to encourage healthy behaviours in their children. Governments have a central role in creating conditions that empower individuals and communities, promote and protect well-being and strengthen resilience (21,22). While all communities need to be empowered and resilient, focus must be placed on facilitating the empowerment of communities at risk of vulnerability. This contributes to creating a cohesive social environment that inhibits the discrimination of groups at risk of vulnerability and lessens the likelihood of them being left behind.
The relationship between empowered and resilient communities and health is bidirectional. Communities that remain disadvantaged and disempowered have disproportionately poorer health and social outcomes (16), while resilient communities have greater awareness and command of their health assets. Health assets can be social, financial, physical, environmental or human resources (education, employment skills, supportive social networks and natural resources) that affect the health of people in a community (19). An empowered and resilient community promotes safe, nurturing and health-enhancing family environments that contribute to creating the enabling conditions for children and their families to thrive (17). This transformative focus on empowerment of individuals is outlined in strategies such as the United Nations Secretary-General’s global strategy for women’s, children’s and adolescents’ health 2016–2030 (10).

Box 2: Case Examples

**Example 1:** Malta has created a system-level approach to meeting challenges small countries face in relation to availability of human resources and to better prepare for global financial or human crises. The focus is on developing, retaining and training the medical workforce. Malta has increased its physician population through intersectoral action and international partnerships.

**Example 2:** Iceland has taken an intersectoral approach to building resilience within its institutions and communities and among individuals for the prevention of child maltreatment. One element is the Barnahus, a multiagency and interdisciplinary centre for investigating and supporting child abuse cases. The model changes child and family experiences to increase resilience and improve recovery from trauma.

**Leave no one behind – recognize vulnerability to fight inequality**

Inequality cannot effectively and sustainably be addressed without a focus on vulnerability. Groups in society can become disenfranchised, suffer from poor access to education and experience increased levels of unemployment. These groups, often minorities, are the most vulnerable in society and subsequently rank worst for mental health issues, health inequalities and access to services. This can be due to policies, or societal values and infrastructure, or governance architecture. It is important to ensure that policy actions do not inadvertently contribute to growing inequalities through interventions that are not sufficiently equity-sensitive (23).

The use of proportionate universalism, an approach which holds that “to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage” (24), is necessary. While a universal social protection floor covers all members of society, groups at risk of vulnerability must be prioritized in proportion to their needs to effectively decrease inequalities. Children and adolescents are a group at risk of vulnerability in general, with greater risk held by particular individuals such as those with parents who misuse alcohol or drugs.
Roma populations in Europe, for example, suffer disproportionately from social and economic exclusion and poor health. They are frequently excluded, face discrimination and consequently experience barriers to accessing good-quality housing, health and social services, and education (25) which affect all members of the community, including children and adolescents. Gaps in the data on Roma health status nevertheless remain, impeding full understanding of their situation and hindering a comprehensive policy response (22,26).

Recognizing vulnerability includes increasing information and data collection on groups at risk of vulnerability and allowing evidence-informed policies to be proportionately focused on those who need attention most, which contributes to the reduction of inequalities throughout society. This has been highlighted as a specific priority in the recently adopted WHO Strategy and action plan for refugee and migrant health in the WHO European Region (27) for addressing the needs of migrant populations in the Region, many of whom are unaccompanied children.

**Box 3: Case Examples**

*Example 1*: In response to increased poverty levels, France created the National Multiannual Roadmap to tackle poverty and social exclusion. The plan is based on five principles, with a focus on prevention, assistance and support, and participation of poorer people, with greater coherence in public policies at national and subnational levels.

*Example 2*: Roma populations in Europe suffer disproportionately from social and economic exclusion and poor health. They are frequently excluded, suffer discrimination and consequently face barriers to accessing good-quality housing, health and social services, and education. Gaps in the data on Roma health status nevertheless remain, impeding full understanding of their situation and hindering a comprehensive policy response.

**Adopt a rights-based approach to ensuring health and well-being**

By clarifying lines of accountability between rights-holders and duty-bearers, a rights-based approach helps to identify strategies and solutions for acting on unjust inequalities and ending discriminatory practices across the life-course (28). In 2003, the United Nations agreed that fulfilling human rights – including the rights of children – should guide development cooperation across all sectors (29). Placing the fulfilment of rights at the heart of intersectoral and interagency action for the health and well-being of children and adolescents helps to ensure sustainable progress through development cooperation by strengthening the capacity of advocates to make claims on behalf of children, and of duty-bearers to meet their obligations.

While children and adolescents require special care and assistance, including legal protection (30), they also have the right to participate in the policy process, which is crucial to the successful implementation of strategies targeted toward improving their health and well-being (14,30). Indeed, a range of actors beyond the state – international organizations, corporations, civil society, communities, children, guardians and families – play a role in protecting the rights of children, safeguarding their entitlements, and ensuring access to legal advocates and
mechanisms for redress as needed. Member States have committed to respecting, protecting and fulfilling rights related to health, education and social protection of all children and adolescents through the ratification of a number of international human rights treaties, including the Convention on the Rights of the Child (30), the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Elimination of all Forms of Discrimination Against Women.

**Box 4: Case Examples**

*Example 1: Montenegro* has increased protections for children through legislative, agency and other intersectoral action. The law has been amended to provide financial support for families at risk of vulnerability, and the Protocol on Intersectoral Cooperation for the Prevention of Child Abandonment/Relinquishment has been signed by the ministries of labour and social welfare, health, and education. Intersectoral efforts to reduce child abuse have been increased and child-care centres expanded.

*Example 2: The Stay Safe education programme in Ireland* is provided by teachers 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. Children who participated in the Stay Safe programme showed significant improvements in safety knowledge and skills at three-month follow-up.

**Adopt a transformative approach to implement the 2030 Agenda for Sustainable Development**

Sustainable development requires a transformative approach, or a joint focus on empowering people and addressing the systemic enablers of vulnerability in a way that supports communities’ ability to respond effectively to external shocks and pressures over time. The recent United Nations Research Institute for Social Development report *Policy innovations for transformative change: implementing the 2030 Agenda for Sustainable Development* (31) states that the United Nations 2030 Agenda:

- can only be realized if the implementation process leads to transformative change addressing the root causes of inequitable and unsustainable outcomes. Transformative change therefore requires fundamental changes in social relations and institutions to make them more inclusive and equitable, as well as the redistribution of power and economic resources.

From a health perspective, a transformative approach requires change in the way the health sector thinks, facilitating a shift away from a focus on the relationship between health and health care (7) to one on understanding the dynamic nature of health and social protection systems. Such an approach makes well-being the unifying concept underlying the health of individuals and populations (7) and acknowledges the full complexity of the subjective, lived experience. It requires that health policies are tailored to the cultural and societal contexts within which they are meant to be applied.
Box 5: Case Example

The Well-being of Future Generations (Wales) Act 2015 in United Kingdom (Wales) represents legislation for sustainable development in response to the 2030 Agenda for Sustainable Development and the Sustainable Development Goals. It aims to improve social, economic, environmental and cultural well-being. Public bodies listed in the Act must perform in a sustainable way and consider the potential effects on people living their lives in Wales in the future when making decisions.

Realize whole-of-government, whole-of-society and HiAP approaches

A transformative approach towards improving the health and well-being of children and adolescents requires new approaches to health governance. Whole-of-government, whole-of-society and HiAP approaches offer strong starting points. The whole-of-government approach refers to “the diffusion of governance vertically across levels of government and arenas of governance and horizontally throughout sectors” (1). A whole-of-society approach advocates for increased engagement with actors relevant to health-policy decision-making beyond the government alone, including the private sector (for-profit and not-for-profit), civil society, communities and individuals (1).

By broadening participation in the policy process, the whole-of-society approach enhances equity, empowers groups and individuals representing rare but significant health concerns, builds trust and instils a greater sense of individual ownership over one's health and future (32). Grounded in the relationship between health-related rights and obligations, the HiAP approach aims to improve population health and reduce health inequalities by systematically evaluating the health impact of policy decisions made across sectors and at all levels of government, with a particular focus on avoiding negative unintended consequences (33). By improving intersectoral governance for health, these approaches create an environment that is better suited to addressing vulnerability and inequality, providing a healthier, more equitable future for children and adolescents.

Box 6: Case Examples

The Healthy Ireland framework is based on the determinants of health. Intersectoral mechanisms were established, with representatives across key government departments. The central goals are to: increase the proportion of people in Ireland who are healthy at all stages of life; reduce health inequalities; protect the public from threats to health and well-being; and create an environment in which every sector of society can play its part.

Austria launched its health-in-all-policies and whole-of-government health targets in 2011. The process constitutes the framework for the national health promotion strategy that is part of nationwide health reform, with headline targets supported by an action plan.
Rationale for action

While life expectancy is increasing across the European Region, health inequalities within and between countries remain (7). Addressing the multiple and intersecting factors that determine health early in the life-course helps to ensure that inequalities are not perpetuated from one generation to the next, and the earlier the investment in health, the greater the social benefit. Through interagency working and strengthened intersectoral governance for health, policy coordination and coherence can be enhanced across the many existing policy frameworks, including the United Nations 2030 Agenda and Health 2020.

The outcome document presents the following rationales for acting now to promote better and more equal health and social outcomes for children, adolescents, their families and communities.

Life expectancy is increasing, but not equally

Average life expectancy has increased across the European Region since 2000 (7). The most recent comprehensive data show that average life expectancy at birth increased from 74 years in 2000 to 78 in 2013 (34). The gap between countries in the Region with the highest and lowest life expectancy has also reduced. In 2000, the gap at birth between countries with the highest and lowest life expectancy was 19 years for males and 15 for females (34), but in 2013, it had reduced to 15 years for males and 11 for females. Specifically, life expectancy for males ranged from 66 years in Kazakhstan to almost 81 in Switzerland, and for females from almost 75 in Kyrgyzstan to 86 in Spain (34).

The Review, however, also identified inequalities between countries with comparable levels of development, geographical areas within the same countries, and social groups within populations. This draws attention to areas where policies might successfully be transferred and where more research, monitoring and evaluation are required (2).

Multiple and intersecting factors determine health

Health and well-being are shaped by multiple and intersecting factors that influence health on their own and in combination. The factors include: years of education, and its quality; gender inequality and stereotypes; working conditions, income level and employment status; family and community resources and services; the quality of housing and the built environment; and environmental exposure. They are affected by a number of forces and systems, including economic policies and systems, development agendas, emerging technologies, social norms, social policies and political systems. Intersectoral collaboration is needed to effectively address these factors, as mandates for action lie beyond the health sector.

Health determinants are not only multifaceted, but are also subject to cultural contexts (35), emerging technologies, and social norms and attitudes, including discrimination and stigmatization. Consideration of the cultural contexts of health can help reduce health inequities by allowing access to different and new forms of evidence (such as narratives) that can amplify marginalized voices (36). The 2016 UNDP regional human development report (4), for example, states that wealth distribution, transparency and accountability in governance, gross domestic product per capita and per capita growth, social support, community networks and water and sanitation, as well as life satisfaction are significantly correlated with self-assessed health. Socioeconomic status/household wealth, gender, educational attainment, family composition
(marital status) and marginalized groups (migration status) are also significantly correlated with self-assessed health status (4).

Collaboration between WHO and the United Nations Educational, Scientific and Cultural Organization (UNESCO) in the European Region has highlighted how cultural contexts affect pressing regional and global health challenges, such as the dramatic rise of obesity and the current migration crisis. Equity-focused policies that address the multiple pathways leading to health inequalities are needed at regional and national levels.

The association between inequality and childhood mental health problems, such as hyperactivity, conduct disorders and anxiety, is strong. These mental health problems are also strongly associated with deprivation, poverty, inequality, and social and economic determinants of health (37). Mental health problems are exacerbated by higher levels of smoking, alcohol and drug abuse, unemployment, obesity and poor nutrition, which affect some populations more than others (38). Comorbidities of mental health problems are also risk factors for noncommunicable diseases, just as noncommunicable diseases are risk factors for mental health. Mental health problems and comorbidities are clustered in the bottom quartile of the population in the European Region (21,38).

Areas of deprivation tend to have high prevalence of families with at least one member living with a mental disorder, thereby perpetuating inequalities. Any family that includes a member with a mental disorder will experience increased costs as a consequence of the burden of care, which may require absence from work and reduced income. Effective treatments and care for mental disorders and their comorbidities must be integrated and comprehensive, targeting the families and children of people with mental health problems (39). To reduce inequalities in mental health and well-being, actions must be universal, integrated and coordinated, but with a scale and intensity proportionate to the needs of groups at risk of vulnerability and disadvantage (21).

**Box 7: Case Example**

In 2015, Norway crafted a solution-focused approach to improving self-esteem in socially withdrawn schoolchildren. This intervention study was based on a solution-focus approach group that was delivered by school nurses. The focus highlights the children’s personal strengths and successes as valuable learning experiences, rather than dealing with their experience of deficits and failures.

**A good start in life for all children is key to health throughout the life-course**

Addressing the root causes of poor health early in life is an important way of generating dividends for the well-being, development, sustainability and resilience of today’s society and for future generations. Children who receive a good start in life – including nurturing care, defined as “health, nutrition, security and safety, responsive caregiving, and early learning provided by parent and family interactions, and supported by an environment that enables these
interactions” (40), are more likely to attain higher-paid employment and have better health and educational outcomes (5,11,41). Nurturing care, comprising adequate nutrition, health care, love and security, protection from danger (including passive smoking) and opportunities to discover and learn, is the foundation for early childhood development. The early years – the first 1000 days from conception followed by childhood up to 8 years of age onward – are especially crucial for brain development, including cognitive, social, emotional and executive functioning, consequently influencing a wide range of outcomes, from health to social adjustment and productivity (20). It therefore is critical that all children, regardless of background, have access to evidence-based interventions and services that support their emotional, mental and physical development, health and well-being from conception.

A number of high-quality early-years services, such as maternal, newborn and child health services at health facilities and in the home (42) that support parental mental health and strengthen caregivers’ capabilities to provide nurturing care, parenting support, child care (20) and early education/pre-school (20,43–45) can mediate the effects of social disadvantage on early childhood development (2), in addition to being cost–effective over the life-course (46). Combined, as opposed to discrete, interventions with the child and parents are more likely to succeed (47). While problems encountered in early life are not immutable, they become more difficult and expensive to remedy later on (48). WHO and the United Nations Children’s Fund (UNICEF) developed Care for Child Development (49) as an intervention to support caregiver child interactions and facilitate opportunities for early learning in the home, from birth through the first three years of a child’s life. Care for Child Development has been introduced in a number of countries in the Region and has effectively been integrated in maternal and child health services, day-care centres and pre-school education services.

**Box 8: Case Examples**

**Example 1:** Tepebaşı municipality in Turkey uses community houses and cultural facilities usually located in the suburbs of the city to reach children and adolescents with projects and services. The project provides support to mothers before and after birth and increased pre-school education to eliminate the inequality in starting a good life.

**Example 2:** Article 6 of France’s Education Law, adopted in 2013, states that health promotion activities fall within the remit of education. The health pathway programme in the curriculum advocates that interventions start as early as possible (in kindergarten) at a time when children are beginning to develop knowledge and skills, and continue through to the end of the curriculum and schooling. It ensures students’ well-being at school and contributes to the fight against social inequalities in health.

**Inequality gaps among children and adolescents can be tackled**

Tackling inequality gaps among children and adolescents is an issue requiring urgent attention, because health outcomes throughout the life-course are shaped by the circumstances in which children grow up, the extent to which their families can offer them a nurturing environment and the experiences they have in and out of the home, including pre-school and school (20). The focus must be on all children and adolescents, with particular attention paid to those who are
excluded and at greatest risk of falling through the gaps. The UNICEF *Fairness for children* report highlights a strong association between family background and children’s outcomes in education, health and life-satisfaction (50). To address this, equity should be placed at the heart of child well-being agendas, the incomes of households with the poorest children should be protected, and data should track children over the life-course (50).

The extent to which early childhood education and care’s potential to address the challenges of inequality can be realized, particularly for traditionally excluded groups like Roma and migrant communities, depends on the design of the system (20). The report of the early years, family and education task group of the Review (20) concludes that:

universal provision makes it more likely that the inequalities characterized by the gradient of disadvantage will be addressed. Family support services are also critical, but can only ameliorate the impact of wider issues of poverty and disadvantage, and do not address the underlying causes of poverty.

This requires political commitment to focusing on the social determinants of health and ensuring the use of proportionate universalism. Attention must be given to population groups at risk of vulnerability, with services made available for families and children who require additional specialized support (2).

Given its reach – from pregnancy through the lifespan – the health sector has a special role to play in tackling these inequalities, as many of the essential interventions for reproductive, maternal, newborn, child and adolescent health have a direct effect on children’s development. The health sector can facilitate the introduction of new interventions, such as UNICEF’s Care for Child Development package (49), UNICEF’s support to universal progressive home visiting services for pregnant women and families of young children in south eastern Europe and the Commonwealth of Independent States (42) and WHO’s *Thinking healthy* for maternal mental health (51). Examples of Member States tackling inequality gaps among children and adolescents are present across the Region, and numerous case studies are available in three volumes accompanying the report of the early years, family and education task group (52–54).

**Box 9: Case Examples**

*Example 1: WHO’s Thinking healthy* manual is a supplement to the mental health gap action programme intervention guide (mhGAP–IG). The mhGAP–IG was developed for use in nonspecialized health-care settings and includes guidance on evidence-based interventions to identify and manage a number of priority mental health conditions, one of which is depression in the perinatal period. The mhGAP–IG describes in detail what to do, but does not go into descriptions of how to do it. Training materials have been developed to support its implementation. The purpose of the *Thinking healthy* manual is to provide detailed instructions on how to implement the evidence-based guidelines of the mhGAP–IG for managing perinatal depression.

*Example 2: The United Nations Children’s Fund Fairness for children* report card reviews child health and well-being equities in 41 European Union and Organisation for Economic Co-operation and Development countries. Its aims are to highlight gaps in childhood inequity among children at the bottom and middle, emphasize the need to address inequity, and explain why fairness for children is so critical to the success of the Region.
Existing policies set the scene for putting evidence into action

Numerous policies, strategies and plans exist at global, regional and national levels to translate evidence into action across the European Region (see Annex 1). The 2030 Agenda for Sustainable Development (55), adopted in September 2015 by all Member States of the United Nations, represents a platform driven by high-level political impetus to bring sectors together and facilitate intersectoral collaboration to achieve the common goals represented by the 17 SDGs. Health 2020 can facilitate this process at regional level. The strategy was adopted by all 53 Member States of the Region in 2012 and reaches beyond the health sector, advocating for partnerships between sectors and actors to improve health and well-being. It encourages other sectors to claim their place as equal partners in working towards the common goal of a healthier future for our young and future generations. In addition, the action plan to strengthen the use of evidence, information and research for policy-making, which was adopted at 66th session of the WHO Regional Committee for Europe, brings sectors together by using intersectoral evidence to support health policy development (56,57).

Member States have also developed a number of core commitments to improve health outcomes for children and adolescents in the Region that contribute to making the current policy climate one of opportunity. These include the European strategy for the prevention and control of noncommunicable diseases (56) the 2015 Minsk Declaration (13), the European child and adolescent health strategy 2015–2020 (14), the European child maltreatment prevention action plan 2015–2020 (58), the strategy and action plan for refugee and migrant health in the WHO European Region (27), the strategy on women’s health and well-being in the WHO European Region (59), and the Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in the WHO European Region – leaving no one behind (60). In the European Union, the Europe 2020 strategy (61) and the south-east Europe 2020 growth strategy (62) are shaping policy agendas. The European Commission’s social investment package (63) emphasizes affordable and accessible child care and education services, and social protection for parents.

At global level, United Nations agencies have also introduced policies that have the potential to affect the health of children, adolescents and their families. The UNESCO Education for All (64) and Global Education First (65) initiatives promote education as a means of fostering creativity, solidarity and sustainability throughout society. The UNESCO Incheon Declaration, Education 2030: Towards Inclusive and Equitable Quality Education and Lifelong Learning for All, adopted at the 2015 World Education Forum, also represents an international commitment to inclusive and equitable quality education, which is imperative to sustainable health and well-being of children and adolescents in the future. The International Labour Organization Future of Work initiative (66) serves as a platform for collaboration between the health and social sectors and employers in pursuing achievement of the 2030 Agenda. The United Nations Economic Commission for Europe Batumi initiative on green economy aims to reduce environmental risks and ecological scarcity, enhance economic progress and improve human well-being and social equity for the transition to a green economy, in line with the 2030 Agenda.
A European framework for action

Enhancing policy coherence and coordination across the plethora of frameworks, strategies, plans, policies, goals and commitments at global, regional, national and subnational levels is critical for efficiently and effectively implementing policies throughout the Region, including those focused on improving child and adolescent health and well-being. Strengthening cooperation through regional dialogue is key to ensuring that WHO European policy frameworks and strategies complement the work of Member States (as opposed to duplicating efforts or creating unnecessary burdens), increase the capacity of health ministries to collaborate with other sectors and partners within and across national boundaries, and improve transnational governance for health when health determinants are located beyond national boundaries. Improved data-collection and -sharing can also contribute to a broader understanding of the challenges faced by children, families and communities at most risk of vulnerability throughout the Region, and to setting Europe-wide standards and guidelines for addressing child and adolescent health and well-being across sectors.

To ensure efficient and effective policy implementation, the following European framework for action will guide this work.

Invest in health through national development strategies

Besides simply improving health, investing in health is also an investment in human development and capacity, prosperity, social and financial protection, national security and the wider economy (67,68). The Lancet Commission on Investing in Health concluded that “country-owned national strategic health plans that identify local priorities and high-impact cost-effective interventions should form the basis for investment” (69), and these health plans must be integrated into national development strategies to ensure political and economic sustainability. The Organisation for Economic Co-operation and Development (OECD) highlights that health is critical to human capital accumulation and labour productivity (70).

The health sector has a unique and key role to play in building the foundation for human capital along the life-course. The health and development of children from birth through adolescence affects long-term health outcomes, economic productivity, social cohesion, security and peace. Essential interventions to promote, protect and support the health of women, children and adolescents are well known and feasible for implementation at scale (71). The global investment case for reproductive, maternal, newborn, child and adolescent health has shown that increasing health expenditure by only US$ 5 per capita per year until 2035 (equivalent to US$ 30 billion per year, and in per capita terms representing a 2% increase in current spending) in the 74 high-burden countries could result in up to nine times that value in economic and social benefits (72).

Similarly, a recent calculation of the cost of inaction in investing in early childhood development showed a 26.6% reduction in productivity among the 43% of children in lower- and middle-income countries who are at risk of suboptimal development due to poverty and stunting. Societal costs of inaction on reducing stunting to less than 15% and providing universal preschool education would exceed by two or three fold the current expenditure for health and/or education as a percentage of gross domestic product in multiple countries (12).
Implement intersectoral and equity-focused policies, strategies and plans

It is crucial to ensure that national health, education and social policy actions do not inadvertently contribute to growing inequalities through interventions that are not sufficiently equity-sensitive (23). There is a delicate balance between implementing universal policies, strategies and plans that are essential to improve population health proportionately, and ensuring that the groups most at risk of vulnerability and marginalization are prioritized (73). To avoid further stigmatization of already marginalized populations, policies should prioritize equity, focusing on those who would otherwise be excluded from health, education or social services because of existing societal barriers.

Equity-focused strategies and plans are being implemented already, both globally and in the European Region (73). Ensuring equity is coherent throughout the policy process is also important. Equity must be an overall goal, but also a specific goal in the policy process: without considering equity in the initial design of the policy, strategy or plan, and at every stage throughout, it is not possible to ensure that an outcome will be equitable and proportionately effective for the needs of different population groups.

Support and expand existing healthy settings networks

Healthy settings, such as health-promoting schools and communities, are crucial to improving health literacy and empowering young people, leading to healthier future generations. The WHO Regional Office for Europe has played a critical role in establishing interdisciplinary networks for health. Examples of long-standing interdisciplinary, politically oriented networks for health include the South-eastern European Health Network (62), the WHO European Healthy Cities
Network (74), the Regions for Health Network (75), and the Schools for Health in Europe Network (76).

Strengthening regional commitment and support to these networks can contribute to fostering healthy communities and realizing the networks’ potential to affect societies throughout the Region. Supporting and expanding the Schools for Health in Europe Network presents a particular opportunity to realize the transformative role schools can play in the wider community, in addition to their role as settings for promoting early childhood development, health and social literacy programmes and delivering related programmes and services. Strengthening cooperation and collaboration between different networks also allows for coherence among levels of healthy settings, from individual entities (schools) to municipal and regional levels, and ensures those most at risk of vulnerability are more likely to be reached: engagement happens with individuals at different levels of society and through different levels of governance.

Box 12: **Case Example**

Building a relationship with the education sector at municipal level has been a key goal and challenge for Belfast Healthy Cities in **United Kingdom (Northern Ireland)**. Teachers 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 may normally identify a direct benefit for schools in collaboration with the health sector, in this instance, the health sector could effectively identify and communicate the shared benefits.

**Set Europe-wide guidelines for public health programmes**

Regional guidelines for public health programmes are necessary to ensure that public health responds to the causes of health inequalities in the most effective way. The final report of the WHO Commission on Social Determinants of Health (15) challenged conventional public health thinking on several fronts. The report responded to a situation in which the gaps within and between countries in relation to income levels, opportunities, health status, life expectancy and access to care were greater than at any time in recent history. It highlighted that improving the health of populations in genuine and sustainable ways ultimately depends on understanding the causes of, and addressing, these inequities.

Public health has undergone a shift towards a focus on further upstream prevention, but this depends on action in other sectors (whether involving trade agreements, food production and marketing policies, road design, or regulations and their enforcement). The health sector and public health programmes need to work with other sectors to realize shared benefits in a whole-of-government approach to health. Equity-focused public health programmes that address wider determinants of health, including social and economic determinants, are important in maximizing the impact of public health approaches (77). Regional guidelines would ensure coherence throughout countries about how best to tackle issues of health inequalities, promoting a healthier life for future generations.
Build the capacity of the workforce to facilitate transformative action

Health workers, which includes community-based health workers, midwives, nurses and doctors, and the wider workforce from other sectors who are supporting the achievement of health objectives (such as social workers, care workers and teaching staff) are an investment not simply in the health system, but also in economic growth and stability (70,78). A substantial transformation of the workforce is required, building the capacity of sector workforces to deliver to a European-wide standard through, for example, expanding the medical training curriculum to include social determinants of health and equity, comprehensive childhood development, participatory and intersectoral approaches, and public health and well-being.

Transforming the workforce across sectors requires a focus on the role the health sector can play as an employer in promoting gender equity and diversifying its workforce (79). Women continue to play a disproportionately large role in paid and unpaid care work across the Region. Consideration of the diverse composition, recruitment strategies and employment conditions of the workforce is important to maximize capacity for meeting current and future health and well-being care needs across the Region (80), ranging from migrant health and cultural competencies to demographic change and long-term care.

Invest in a regional approach to commercial factors affecting determinants of health

Investment in a regional approach to commercial factors affecting determinants of health is crucial to improving the health and well-being of children and adolescents in the Region. Evidence suggests that children and adolescents are especially vulnerable to marketing pressures and to adopting behaviour that increases their risk of contracting noncommunicable diseases, making governance of the commercial determinants of health a priority area for action (81,82). Concerted efforts to act early across government and with wider society to mitigate the negative effects of commercial interests on the health of children and adolescents is also an investment in health in later life, since adolescence is critical in determining adult behaviour in relation to noncommunicable disease risk factors, such as tobacco and alcohol use, dietary behaviour and physical activity.

New commercial factors are also playing an increasingly important role in how families and individuals access and interact with health and social protection information and services. Evidence that electronic media use can positively and negatively affect adolescents’ health, social and emotional development and perception of health-related behaviours highlights the importance of continuing to monitor the changing nature of peer relations to better understand their impact (14,20).

Collect data and evidence strategically to provide evidence-informed policies

The generation and use of sound evidence for policy should be placed at the centre of WHO work in the Region. Robust and strategically collected evidence allows policy-makers to make informed decisions about how to tackle issues of health equity and well-being, and to monitor and evaluate their outcomes. This requires continuous efforts to strengthen data-collection, analytical and research capacity, and knowledge-translation among countries in the Region. A transformative approach to health also requires new strategies for collecting evidence that
explore non-traditional data sources, a wider range of qualitative methodologies and greater direct involvement of stakeholders and beneficiaries in research design. Concepts such as subjective well-being, empowerment and community resilience are now routinely invoked in public health policies.

Measuring and reporting on these concepts across culturally diverse populations in ways that are meaningful and engaging to policy-makers remains a significant challenge. The WHO European health report for 2015 outlines the necessity of accurately collecting and reporting data to inform policy, develop new approaches to measuring health-related concepts and coordinate work through the European Health Information Initiative (7). The Initiative is a WHO network of stakeholders, including Member States but also the OECD and the European Commission, committed to enhancing health in the Region by improving the information and evidence that underpins policy and supporting the development of a single European health information system, as first outlined in the joint declaration adopted by the Regional Office and the European Commission in 2010 (83). This was confirmed by Member States in the European action plan as a regional vision to strengthen the use of research and evidence in policy-making. The recent increase in migration to the Region has resulted in calls to enhance regional capacities to collect data and ensure data-collection is migrant-sensitive, and in a direct call for Member States to “strengthen health information systems for improved data collection on refugee and migrant health” (23).

**Box 13: Case Example**

The European Health Information Initiative is a multimember WHO network that is committed to improving the health of people in the WHO European Region by enhancing the information on which policy is based.

**Strengthen regional cooperation for better health and well-being for all in the Region**

Given the plethora of policies, initiatives, strategies and plans already in place across the Region that aim to guide countries towards commitments and goals, strong regional partnerships and interagency coordination are key to implementing policies in an efficient and effective manner. Strengthening regional cooperation through continued regional dialogue is important to reduce the duplication of effort, thereby increasing the efficiency of policy implementation in a way that lessens, rather than increases, the burden placed on Member States. This also applies to cooperation among Member States, agencies in the United Nations system, other international organizations and partners, civil society and the private sector.

From a health perspective, it is necessary to recognize that the global and regional dimensions that affect the work of ministries of health have become increasingly relevant, emphasizing the need for regional cooperation. Ministers of health now play a more active role nationally and internationally, as many of the challenges they face extend beyond domestic policies and borders (84). Strengthened regional cooperation will increase their capacity to collaborate with other sectors and partners within and across borders. Subregional health information networks (such as the Central Asian Republics Health Information Network, the Evidence-informed Policy...
Network and the European Health Information Initiative) are good examples of regional cooperation through which countries with similar challenges work together to improve the generation and use of information for policy.

Investing in strengthened regional cooperation can also contribute to addressing governance issues surrounding wider determinants of health (social and commercial). This is especially important for commercial determinants, which affect the marketing, accessibility, availability and affordability of tobacco, alcohol and food high in salt, sugar and fat, thereby having an effect on the health behaviour of children and adolescents (85). Strong regional cooperation and governance is necessary to ensure that commercial determinants of health do not lead to increased health inequalities throughout the Region.

Regional cooperation and dialogue will also contribute to strengthening Region-wide understanding of the challenges faced by children, families and communities most at risk of vulnerabilities through improved collection and sharing of data and evidence on topics such as: access to education, health and social care for migrant children; children at risk of vulnerability, including minorities; children with disabilities; and children from low-income or chaotic homes. This responds to issues raised in the WHO European health report for 2015 (7) and the recently adopted WHO strategy and action plan for refugee and migrant health in the Region (27), and is an important element in ensuring the sustainability of progress made.
References


Annex 1

RELEVANT POLICY FRAMEWORKS

Table A1.1 presents relevant policy frameworks with weblinks.

Table A1.1. Relevant policy frameworks with weblinks

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Annex 2

RELEVANT COUNTRY EXAMPLES SHOWCASING COLLABORATION AMONG HEALTH, SOCIAL AND EDUCATION SECTORS

Box 1: Act with urgency to improve health equity and the social determinants of health
In response to the global crisis, the government of Iceland set up Welfare Watch, a system to monitor and respond to social and financial effects felt by families and individuals. The programme focuses on at-risk populations such as children, young families, people with disabilities, those with long-term illnesses and older people.

After conducting surveillance on overweight and obesity, Cyprus developed a national nutrition plan in 2008 to prevent noncommunicable and communicable diseases in children and adults. It addresses the issue of overweight and obesity at all life stages. Cyprus has also used this strategy to develop a programme for its migrant population.

Box 2: Improve the health of all families and create empowered and resilient communities
Malta has created a system-level approach to meeting challenges small countries face in relation to availability of human resources and to better prepare for global financial or human crises. The focus is on developing, retaining and training the medical workforce. Malta has increased its physician population through intersectoral action and international partnerships.

Iceland has taken an intersectoral approach to building resilience within its institutions and communities and among individuals for the prevention of child maltreatment. One element is the Barnahus, a multiagency and interdisciplinary centre for investigating and supporting child abuse cases. The model changes child and family experiences to increase resilience and improve recovery from trauma.

Box 3: Leave no one behind – recognize vulnerability to fight inequality
In response to increased poverty levels, France created the National Multiannual Roadmap to tackle poverty and social exclusion. The plan is based on five principles, with a focus on prevention, assistance and support, and participation of poorer people, with greater coherence in public policies at national and subnational levels.

Roma populations in Europe suffer disproportionately from social and economic exclusion and poor health. They are frequently excluded, suffer discrimination and consequently face barriers to accessing good-quality housing, health and social services, and education. Gaps in the data on Roma health status nevertheless remain, impeding full understanding of their situation and hindering a comprehensive policy response.

Box 4: Adopt a rights-based approach to ensuring health and well-being
Montenegro has increased protections for children through legislative, agency and other intersectoral action. The law has been amended to provide financial support for families at risk of vulnerability, and the Protocol on Intersectoral Cooperation for the Prevention of Child Abandonment/Relinquishment has been signed by the ministries of labour and social welfare, health, and education. Intersectoral efforts to reduce child abuse have been increased and child-care centres expanded.

The Stay Safe education programme in Ireland is provided by teachers 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. Children who participated in the Stay Safe programme showed significant improvements in safety knowledge and skills at three-month follow-up.

**Box 5: Adopt a transformative approach to implement the 2030 Agenda for Sustainable Development**

The Well-being of Future Generations (Wales) Act 2015 in United Kingdom (Wales) represents legislation for sustainable development in response to the 2030 Agenda for Sustainable Development and the Sustainable Development Goals. It aims to improve social, economic, environmental and cultural well-being. Public bodies listed in the Act must perform in a sustainable way and consider the potential effects on people living their lives in Wales in the future when making decisions.

**Box 6: Realize whole-of-government, whole-of-society and health-in-all-policies approaches**

The Healthy Ireland framework is based on the determinants of health. Intersectoral mechanisms were established, with representatives across key government departments. The central goals are to: increase the proportion of people in Ireland who are healthy at all stages of life; reduce health inequalities; protect the public from threats to health and well-being; and create an environment in which every sector of society can play its part.

Austria launched its health-in-all-policies and whole-of-government health targets in 2011. The process constitutes the framework for the national health promotion strategy that is part of nationwide health reform, with headline targets supported by an action plan.

**Box 7: Multiple and intersecting factors determine health**

In 2015, Norway crafted a solution-focused approach to improving self-esteem in socially withdrawn schoolchildren. This intervention study was based on a solution-focus approach group that was delivered by school nurses. The focus highlights the children’s personal strengths and successes as valuable learning experiences, rather than dealing with their experience of deficits and failures.

**Box 8: A good start in life for all children is key to health throughout the life-course**

Tepebaşı municipality in Turkey uses community houses and cultural facilities usually located in the suburbs of the city to reach children and adolescents with projects and services. The
project provides support to mothers before and after birth and increased pre-school education to eliminate the inequality in starting a good life.

Article 6 of France’s Education Law, adopted in 2013, states that health promotion activities fall within the remit of education. The health pathway programme in the curriculum advocates that interventions start as early as possible (in kindergarten) at a time when children are beginning to develop knowledge and skills, and continue through to the end of the curriculum and schooling. It ensures students’ well-being at school and contributes to the fight against social inequalities in health.

Box 9: Inequality gaps among children and adolescents can be tackled

WHO’s Thinking healthy manual is a supplement to the mental health gap action programme intervention guide (mhGAP–IG). The mhGAP–IG was developed for use in nonspecialized health-care settings and includes guidance on evidence-based interventions to identify and manage a number of priority mental health conditions, one of which is depression in the perinatal period. The mhGAP–IG describes in detail what to do, but does not go into descriptions of how to do it. Training materials have been developed to support its implementation. The purpose of the Thinking healthy manual is to provide detailed instructions on how to implement the evidence-based guidelines of the mhGAP–IG for managing perinatal depression.

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Box 10: Invest in health through national development strategies

The health transformation programme in Turkey was based on theoretical knowledge from the literature and up-to-date case examples from various countries. It was concluded in just eight years and proved a good example of knowledge, competence and experience combining to create successful outcomes. The programme aimed to improve the governance, efficiency and quality of the Turkish health sector. Continued successful implementation is dependent on tracking its effect on health outcomes, outputs and structures.

Box 11: Implement intersectoral and equity-focused policies, strategies and plans

The national strategy to reduce social inequalities in health in Norway, published in 2007 by the Ministry of Health and Care Services, highlighted public health policy as an intersectoral issue. Norway launched its comprehensive reporting system, which includes annual policy reviews and other implementation tools, the Public Health Act, the Planning and Building Act, health impact assessments and grants for local authorities working in health.

Box 12: Support and expand existing healthy settings networks

Building a relationship with the education sector at municipal level has been a key goal and challenge for Belfast Healthy Cities in the United Kingdom (Northern Ireland). Teachers 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 may
normally identify a direct benefit for schools in collaboration with the health sector, in this instance, the health sector could effectively identify and communicate the shared benefits.

**Box 13: Collect data and evidence strategically to provide evidence-informed policies**

The European Health Information Initiative is a multimember WHO network that is committed to improving the health of people in the WHO European Region by enhancing the information on which policy is based.
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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