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The Nordic–Baltic workshop on the prevention of child maltreatment: strengthening intersectoral working

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ABSTRACT

In line with WHO's European policy for health and well-being, Health 2020, which highlights the importance of intersectoral work, the WHO Regional Office for Europe, the Nordic Council of Ministers, and the ministries of health and welfare of Latvia jointly organized the Nordic–Baltic workshop on the prevention of violence against children. The workshop aimed to bring together experts and stakeholders from key sectors, including policy-makers, professionals and activists from Nordic and Baltic countries. The goal was to promote exchange of expertise in intersectoral responses to the prevention of violence against children. This report summarizes presentations and outputs from the workshop.

Keywords

Child Abuse - prevention and control
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Acronyms

ACE	adverse childhood experience
NCD	noncommunicable disease
NFP	Nurse–Family Partnership
NGOs	nongovernmental organizations
OBPP	Olweus [®] Bullying Prevention Program
RCT	randomized controlled trial
SDG	(United Nations) Sustainable Development Goal
SEEK [™]	Safe Environment for Every Kid (model)
Triple-P	Positive Parenting Programme

Scope and purpose

Child maltreatment is defined as physical, sexual or emotional abuse, and/or deprivation and neglect. Prevalence in the WHO European Region ranges from 9.6% for sexual abuse, to 22.9% for physical abuse, to 29.1% for emotional abuse. This suggests that tens of millions of children are abused before the age of 18 years.

Child maltreatment is one of the more serious forms of adverse childhood experiences (ACEs),¹ though other adversity may also present.

The lack of safe and nurturing relationships in childhood are thought to adversely affect neurodevelopmental change and, in turn, emotional, cognitive and behavioural development. ACEs are linked to a propensity for increased violence later in life and health-harming behaviours, such as alcohol and drug misuse, physical inactivity, depression and self-harm, leading to poor health outcomes, including those due to increased noncommunicable diseases (NCDs) and psychiatric disorders.

The scale, risks, consequences and evidence base for preventive action and policy options are summarized in the *European report on preventing child maltreatment*. All 53 Member States of the WHO Regional Committee for Europe gave unanimous support to resolution RC64/R6 on investing in children: the European child and adolescent health strategy 2015–2020 and the European child maltreatment prevention action plan 2015–2020. This calls for leadership by the health sector in coordinating an intersectoral prevention response that focuses on improving surveillance, developing a comprehensive national action plan for prevention, and implementing prevention programmes.

The United Nations Convention on the Rights of the Child requires all Member States to offer effective child protection. The United Nations Sustainable Development Goal (SDG) Target 16.2 calls for ending abuse, exploitation, trafficking and all forms of violence against, and torture of, children. In addition, the World Health Assembly adopted the *Global plan of action to strengthen the role of the health sector within a multisectoral response to address interpersonal violence, in particular against women and girls, and against children* in 2016.

The Minsk Declaration on the life-course approach highlights the importance of investing in early childhood development and promoting safe, stable and nurturing relationships to prevent ACEs and maximize developmental potential, with improved health and social outcomes as adults.

Latvia has shown great commitment and demonstrated considerable progress in violence prevention, and is one of the first countries in Europe to ban corporal punishment. Violence prevention is a priority for collaboration between the WHO Regional Office for Europe and the Ministry of Health of Latvia. The framework of the Biennial Collaborative Agreement between the Ministry of Health and WHO identifies activities focusing on strengthening the health sector response, including the development of national guidelines on responding to violence for reproductive health workers, the introduction of capacity-building programmes using WHO's

¹ ACEs may be one or more of the following: emotional, physical and/or sexual abuse; physical and/or emotional neglect; substance misuse and/or mental illness among family members; violent treatment of the mother; separation or divorce of parents; and imprisonment of a family member.

TEACH–VIP curriculum, and a survey of ACEs among college and university students. A policy dialogue to disseminate and debate results was held in 2014.

In line with WHO’s European policy for health and well-being, Health 2020, which highlights the importance of intersectoral work, the WHO Regional Office for Europe, the Nordic Council of Ministers, and the ministries of health and welfare of Latvia jointly organized the Nordic–Baltic workshop on the prevention of violence against children. The workshop aimed to bring together experts and stakeholders from key sectors, including policy-makers, professionals and activists from Baltic and Nordic countries. The goal was to promote exchange of expertise in intersectoral responses to the prevention of violence against children.

The objectives of the workshop were to:

- discuss the role of the health, welfare, education and justice sectors in an intersectoral response to preventing violence against children, and how this could apply to Latvia and other Baltic countries;
- provide a platform for sharing recent examples of good practice on preventing violence in childhood from the Region, with a focus on Nordic countries;
- exchange evidence-based experience on implementing programmes consisting of home visitation, positive parenting, preschool education and violence-free schools;
- debate how policy and programming may be improved to tackle this leading cause of childhood burden;
- encourage the development of networks to strengthen child violence prevention in the Nordic–Baltic subregion; and
- promote policy and scientific partnerships among Baltic and Nordic countries to prevent violence in children.

Opening session

The workshop was opened by **Dr Santa Livina, Head of the Public Health Department of the Ministry of Health of Latvia**, who stated that violence affects children’s social development, current and future health, and educational potential; children affected by violence may also display violent behaviour themselves as they grow older. The Ministry of Health has prioritized this issue in its plans for promoting social health, placing special emphasis on strengthening intersectoral cooperation for prevention.

Ms Līga Āboliņa, Deputy State Secretary at the Ministry of Welfare of Latvia, noted that the broad representation from different countries and organizations at the workshop illustrated that child maltreatment was a key priority issue. The common objective is a world in which no child suffers violence or maltreatment.

Dr Dinesh Sethi, Programme Manager for Violence and Injury Prevention at the WHO Regional Office for Europe, highlighted that Target 16.2 of the SDGs aims to stop violence against children by 2030. The workshop presented an opportunity to exchange the expertise that will be vital to achieving that goal. This requires measures not only to respond to violence against children, but also to prevent it.

The European child maltreatment action plan has three objectives:

- make child maltreatment more visible
- develop national action plans to coordinate intersectoral activity for prevention
- deliver intersectoral programmes.

The objective of this workshop was to promote this multisectoral approach.

Mr Anders Geertsen, Head of the Department for Education and Welfare in the Nordic Council of Ministers, said the Nordic Council of Ministers was formed to make collaboration between the governments of Denmark, Finland, Iceland, Norway and Sweden easier across a wide range of sectors.

The Nordic–Baltic collaboration is very strong, and very important, especially in three areas:

- the NORPLUS exchange education programme that brings more than 10 000 students and scholars in the eight countries together every year;
- digitization, with a ministerial conference in 2017 promoting cross-border collaboration; and
- combatting human trafficking.



Background and context

Background and context to the workshop were provided by Ms Lisbeth Zornig Andersen, Dr Dinesh Sethi and Professor Mark A. Bellis.

A survivor's view on the need for prevention

Ms Lisbeth Zornig Andersen, Huset Zornig, Denmark

Lisbeth was abused as a child by her stepfather, as were at least two of her three older brothers. Her parents had a history of alcohol abuse and were divorced when she was 3 years old. Her mother's new husband was a paedophile. The family moved from the capital of Copenhagen to a place in a remote setting, where no one saw what was going on.

A teacher took an interest in Lisbeth when she was 12. He recognized that something was wrong in the household and gave Lisbeth a number she could ring, which she did immediately. Three hours later, she was removed from the family home and placed in a children's home.

She did not respond well to this home and was moved to another one when she was 14. There she met a woman who became her significant adult. Their relationship remains strong to this day, and together they have published a book for parents.

Lisbeth's three brothers developed addictions, and two were imprisoned. They did not talk about the sexual abuse with Lisbeth – other forms of abuse, yes, but never the sexual abuse. One brother died at age 53 in 2016, one committed suicide when 39, so only one survives. He bears the signs of long years of abuse.

Lisbeth believes that her brothers looked after her, but even more significant was her meeting people who cared for and loved her and helped her believe she could actually be something. Her brothers did not have such people in their lives; indeed, most of the people who survive sexual abuse do not.

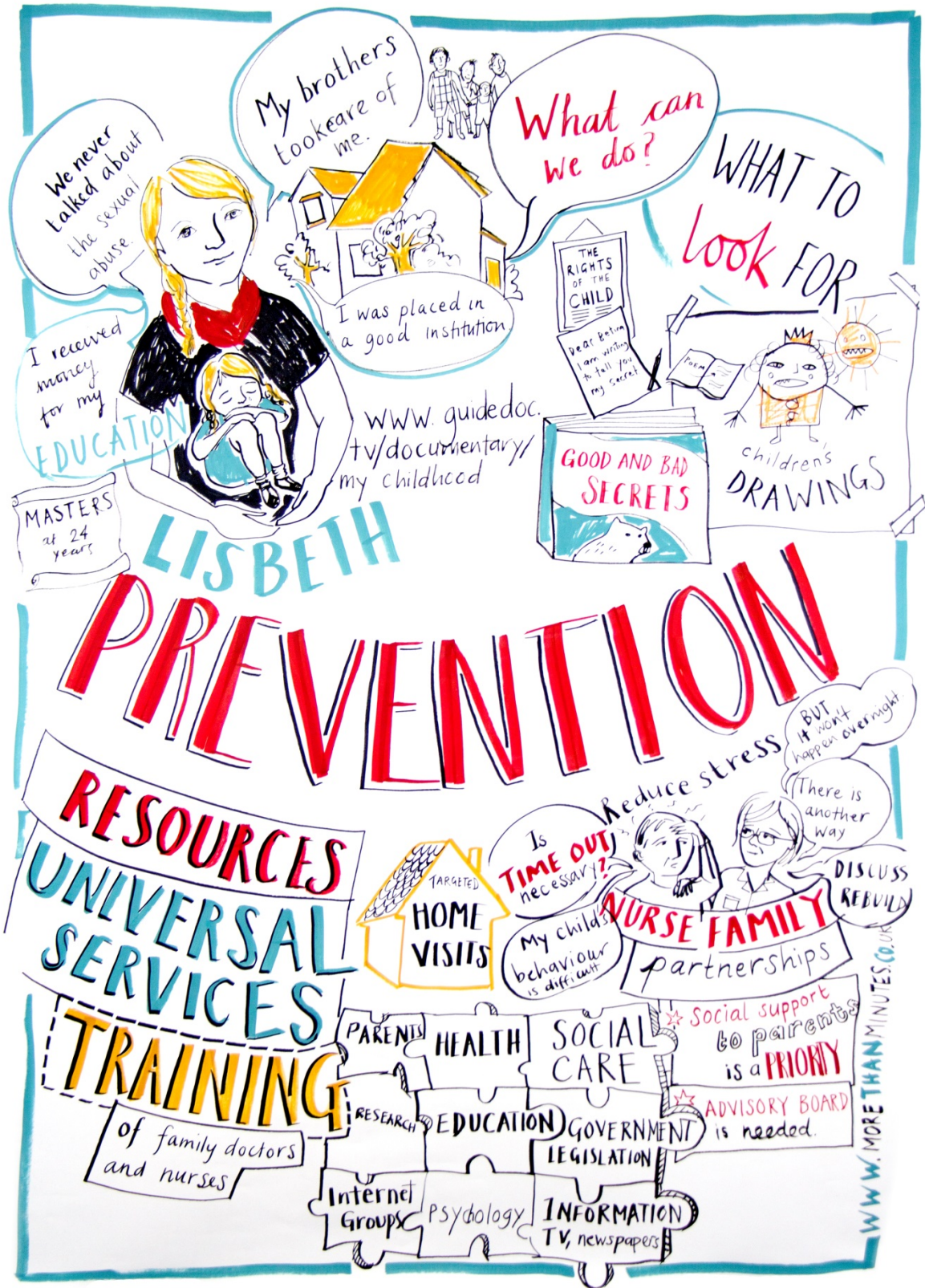
So what helps? Lisbeth suggested two elements are crucial:

- spot the trouble early in children
- help them talk about what hurts.

This is not easy, but Lisbeth's social innovation company, Huset Zornig, has developed a number of resources to help children to talk and a handbook on how to spot the signs of sexual abuse in children, with recommendations on how to respond.

Many children are not educated in their rights, especially Article 34 of the Convention on the Rights of the Child on being protected from sexual abuse. They need to know their rights before they can claim them.

Lisbeth said that the thing that would have made the biggest difference in her early life would have been if the grown-ups around her had listened to her and spent time with her. Even one contact person who was there and was consistent could have made a huge difference.



The life-course approach and preventing child maltreatment

Dr Dinesh Sethi, Programme Manager for Violence and Injury Prevention, WHO Regional Office for Europe

Childhood and adolescence are periods of vulnerability during which the brain is developing. Toxic stress during these times, such as that created by violence and maltreatment, can impair brain networks, resulting in the potential of health-harming behaviours and even early death. While there are few homicides of young people under 15 years in the WHO European Region, rates vary across the Region.

Recent data suggest around 1 billion children in the world have experienced sexual, physical or emotional abuse in the last 12 months. Work in the European Region shows maltreatment is very common, with millions of children being affected by age 18. Only around 10% of it, however, comes to the attention of authorities. This emphasizes the importance of prevention.

ACEs of all kinds lead to life-long and far-reaching consequences, including social, emotional and learning problems, perpetration of violence, health-harming behaviours, NCDs, mental health problems, low productivity and increasing inequalities. Surveys of university students in European countries show that even in this relatively privileged group of young people, ACEs are common: the average prevalence for physical abuse, for example, is 18.6%.

The cost of child maltreatment is very high – in the United States of America, for instance, it is estimated at US\$ 210 000 per victim per year (higher than comparable costs for people with stroke or diabetes), amounting to 1% of total gross domestic product over lifetimes. Studies also show costs in countries like Italy and Germany are very high.

Stopping all of this means acting in time, not just with children, but also with families. Intimate-partner violence and violence against women are very common, and it is known that 40% of children living in households with intimate-partner violence experience maltreatment. Early action is therefore required at societal (legislation and policy), community (addressing issues such as poor social capital and access to drugs and alcohol), relationship (family conflict and domestic violence) and individual levels to prevent maltreatment occurring in the first place.

Measures that work have been identified, from legislation and changing social norms to reducing poverty, providing positive parenting support in the home and community, and preschool education. These will only be effective, however, if there is collaboration across sectors. Many of the multisectoral programmes to be discussed at the workshop are already of proven value, with high benefit–cost ratios. In addition, the international Health Behaviour in School-aged Children survey, which takes place every four years, is to include an optional module on violence, providing countries with a great opportunity to collect more and better data. Countries are encouraged to include this module in future surveys, with the next due in 2018.

The SDGs are closely interlinked. If the SDG targets linked to the risks and determinants of maltreatment are achieved, it will reduce child maltreatment; but unless child maltreatment is reduced, many of the SDG targets will not be achieved. The SDGs provide a policy framework that offers a great opportunity for multisectoral working.

ACEs – the costs of doing nothing and opportunities for intervention

Professor Mark A. Bellis, Director of Policy, Research and International Development, Public Health Wales, Professor of Public Health, Bangor University

The brain of a child who faces prolonged stress produces responses that place the child in a constant heightened state of alert. This has social and health consequences: the part of the brain that deals with life preservation becomes overactive, meaning the child may interpret neutral cues as threatening and see threats in all kinds of situations, including school. Consequences for health include disrupted nervous, hormonal and immune development, social, emotional and learning problems, health-harming and criminal behaviours, NCDs with disability, social problems and low productivity, and early death.

People who have experienced four or more ACEs are four times as likely to be a high-risk drinker, six times as likely to have had or caused a teenage pregnancy, 15 times as likely to have committed violence in the last 12 months, 16 times as likely to have used crack cocaine or heroin, and 20 times as likely to have been incarcerated than those who have never experienced ACEs. If not interrupted, ACEs tend to have intergenerational transmission.

Getting rid of ACEs could lead to widespread benefits for societies, including large reductions in drug use, violence perpetration and incarceration, and for individuals, with reductions in teenage pregnancies, high-risk drinking, early sex, smoking and poor diets.

ACEs also have large effects on mental well-being, with people with four or more ACEs having low mental well-being scores. People with ACEs are, for instance, less likely to feel close to other people, think clearly and feel optimistic about their future.

Some of the biggest, and costliest, NCDs are associated with ACEs. Work in the United Kingdom (Wales) adjusted for deprivation shows that by age 59, 21% of people with no ACEs have at least one NCD (such as cancer, stroke, diabetes or liver or respiratory disease): the comparable proportion for people with four or more ACEs is 41%. Effectively, this means that the health of people with four or more ACEs is ageing about 10 years faster. All this leads to huge costs for individuals and services.

ACEs are also associated with inequalities. In the United Kingdom (England), for instance, three times more people in the poorest fifth of the population have four or more ACEs than in the wealthiest fifth.

Not everyone who experiences ACEs develops long-term problems, however. Resilience can be built through feelings that hardship can be overcome and being equipped to manage behaviour and emotions. The strongest factor in promoting resilience is having one or more stable, caring child–adult relationships. Education also has a part to play, with positive teacher–student relationships producing benefits in children’s behaviours and performance. A trusted adult can make a remarkable difference.

ACEs are a major contributor to ill health and service pressures and costs, but are preventable.

Multisectoral collaboration: how governments can respond

A panel session on multisectoral collaboration and government responses formed the centrepiece of the workshop. The session was facilitated by Dr Alexander Butchart, Coordinator, Violence Prevention, WHO headquarters.



Ms Liga Abolina, Ministry of Welfare, Latvia, said Latvia’s work on strengthening collaboration on child maltreatment prevention and prevention of violence against women is reflected in national policy documents and the national development plan for 2014–2020. Despite corporal punishment of children being banned in 1998, tolerance of violence in Latvia remains high; other preventive measures have therefore been introduced. Intersectoral cooperation is still rather weak, and while good laws are in place, implementation remains patchy, with insufficient skills available to detect violence. Specialist organizations have nevertheless been carrying out preventive activities for over 10 years, and a child hotline is available seven days a week.

Dr Audrone Astrauskiene, Ministry of Health, Lithuania, noted that Lithuania passed a law against domestic violence five years ago, which has inspired a new approach to violence in the country. A national programme and action plan that includes all sectors has been developed, with the main aims of increasing public awareness and improving public support for victims. This year, the law on protecting children’s rights was amended to prohibit corporal punishment, but multisectoral cooperation and implementation around this action remain problematic. It is recognized that child maltreatment is related to alcohol, and attempts have been made by the government to impose further alcohol measures, including raising the legal drinking age to 20.

Dr Ola Florin, National Board of Health and Welfare, Sweden, prepared Sweden's strategy for preventing men's violence against women, which incorporates elements of child protection. The key sectors covered by the strategy are health, social services, criminal justice and education, three of which are responsibilities of local or regional decision-making bodies. When central governments promote multisectoral work, they need to address the political autonomy of local and regional levels; local and regional levels also need to be supported to better estimate the costs of interventions against violence.

Ms Asta Dilyte, Ministry of Education and Science, Lithuania, said progress is being made to expand the child protection framework. Positive parenting training is offered through education services and violence-prevention programmes are also in place in just over 4% of schools. A new programme on health, sexuality education and preparing for family life will be introduced to school curricula from September 2017. This will focus on teaching family and parenting skills from an early age. The new law on education from 2016 has brought in some positive changes in relation to school-violence and bullying prevention, and has obliged schools to implement preventive programmes related to social and emotional skills development: 53.7% of schools are currently implementing such programmes, with the aim of 100% coverage by 2020.

Dr Freja Ulvestad Kärki, Directorate of Health, Norway, noted that a ministerial working group on child maltreatment meets regularly, allowing greater understanding of cultures and knowledge to develop across ministries and promoting shared responsibility. A national centre for violence and trauma stress studies was created in 2003 with five regional centres established subsequently, working very closely with professionals. Tailored training for staff in emergency centres is in place to ensure physicians and nurses understand violence and abuse, and an online learning tool for general practitioners on intimate-partner violence, including forced marriage and female genital mutilation, has been created. Health services have access to a clinical guideline on how to detect violence exposure and several other sector-specific initiatives are in place.

Dr Pirjo Lillsunde, Ministry of Social Affairs and Health, Finland, explained that her country is currently preparing large-scale health and social service reform. This will include a focus on domestic violence and child maltreatment, with the government launching a key project on child and family services that aims to strengthen services and improve early detection of problems. Corporal punishment was prohibited in 1984, and studies show that it has significantly decreased since then. Finland adopted a five-year action plan to reduce corporal punishment in 2010, with a multisectoral working group currently drafting a new programme. Multisectoral collaboration has also been promoted through legislative acts that aim to improve information-sharing among professionals and ensure children at risk are identified and information passed to the appropriate authorities.

Ms Tiina Tõemets, Children and Family Department, Ministry of Social Affairs, Estonia, reported that the country's violence-prevention strategy, coordinated by the Ministry of Justice with involvement of several other ministries, and the strategy for children and families are very important. A child protection law was passed in 2016, and corporal punishment is prohibited. Estonia's first children's house to receive maltreated children opened in January 2017, which provides a very good example of collaboration and a child-friendly justice system. Plans are now being put in place to establish integrated services at local level. Challenges include how to involve the health-care system in collaboration, dealing with lack of human and financial resources, and developing more data to support prevention work.

Dr Bjarne Laursen, National Institute of Public Health, Denmark, said that all children in his country are visited by home nurses at least four times in the first year, with regular follow-up thereafter. Practically all children are entered into day care then preschool, so are seen by many professionals. In principle, Denmark should therefore be able to spot almost all cases of child abuse, but people do not always report their suspicions. This is why reforms made in 2011 make it a duty to report suspicions to social services and allow professionals to exchange information across sectors without parental consent. A plan with specific objectives for child protection was launched in 2014, including education for day-care and preschool staff on reporting suspicions. Work is underway to enable better exchange of information between nongovernmental organizations (NGOs) and social services.

Ms Guðríður Bolladóttir, Ministry of Welfare, Iceland, commented on the involvement of children in policy-making. Last year, the government held a national consultation meeting on violence to inform a four-year action plan, with as many stakeholders as possible included – professionals, NGOs, survivors, people with immigrant backgrounds, people with disabilities and, most important, young people. A number of ideas that came directly from young people are to be included in the action plan, including strengthening their education on the Convention on the Rights of the Child.

Questions to the panellists focused on addressing the potential problem of how investment in child maltreatment prevention in one sector may lead to gains in another – investing in health care, for instance, may result in gains not for health care, but for the criminal justice system. **Dr Freja Ulvestad Kärki** acknowledged that the issue of sectoral investment was important, but that it must be recognized that it is the same children who are exposed to all those services who benefit – the only way to develop a shared understanding of this is to develop a common culture across sectors at all levels.

Country approaches

Specific country approaches from Norway, Sweden and Latvia were described at the workshop.

Bringing about change in Norway: national policy action to stop violence against children

Dr Anne Lindboe, Ombudsman for Children, Norway

Dr Lindboe described the role and function of the Ombudsman for Children in her country, which was the first to appoint a children's ombudsman. It has several elements, including advocacy at political level and providing direct education to children on their rights. Slapping of children is no longer considered acceptable and zero tolerance was enshrined in law in 2010 (corporal punishment was banned in schools in 1936), but many children still do not realize this. Measures are now in place to teach children about boundaries and their rights.

The Ombudsman Office's actions related to child maltreatment aim to prevent, detect, protect and follow-up. Prevention actions include strengthening of public health clinics, where parents are now being given the opportunity to learn about violence and the risks it presents. Home-visiting programmes make it easier to detect problems such as mental health issues, poverty and neglect. Parental guidance programmes are in place to help parents who have problems across a range of issues, including how to respond in non-violent ways to challenges around their child.

Detection is promoted through educating key players, like teachers, police officers and health-care workers, not only how to detect violence, but also how to respond when they suspect a child is at risk. Child welfare services play a key role in protection, but it may be difficult for children to access them direct. The Ombudsman Office therefore lobbied for a national child hotline service, which was subsequently set up.

Strong follow-up systems are lacking in Norway. Some children need medical and psychiatric interventions, but the need for support is universal, and it is very important that follow-up systems recognize this.

An action plan to stop violence and sexual assaults against children was passed in April 2017, representing collaboration among ministries of health, education, justice and children. The Ombudsman Office is currently working on a project on violence and sexual assaults against children that involves hearing what children and young people want from the health sector and hosting a high-level meeting to create a declaration committing to specific concrete measures.

Progress in Sweden in preventing child maltreatment

Professor Staffan Janson, Karlstad and Örebro universities, Sweden

Sweden has a long history of actions to reduce violence. Prominent among them are the banning of corporal punishment of children, first in schools (1958) and then throughout society (1979). Evidence shows that the number of parents who are positive about spanking their child and the incidence of spanking in the previous 12 months has reduced markedly (from 95% and 55% respectively in the 1960s, to 8% and 4% in 2011). The numbers of children killed in Sweden has also decreased, from 15 a year in the 1970s to four a year in 2010.

Reasons for these impressive statistics are not exactly clear, but could include:

- the influence of the welfare state
- technical developments making life easier

- early political consensus leading to early protective legislation
- high educational levels in the population, especially among women
- high levels of economic and gender equity
- preventive health care for all and education for parents on caring for children
- most children being in the public sphere early through preschools
- increased understanding of the connection between family violence and child abuse.

Sweden has also made good progress in relation to ensuring prevention measures cover the whole population, rather than focusing primarily on high-risk groups.

The Swedish experience suggests that attitudes and behaviours can be influenced and changed when there is:

- increased societal awareness of children as bearers of human rights;
- political consensus on laws combined with effective mass information campaigns;
- equity in law between assaults on children and adults;
- universal prevention measures in place (such as midwives raising issues on family violence with women at pregnancy check-ups);
- support for families through the welfare state (parental leave and provision of preschools, for example); and
- profound understanding of the imminent and future risks of child maltreatment.

Parenting and preschool support in Latvia

Ms Agnese Sladzevska, Centre Dardedze, Latvia

The NGO Centre Dardedze views multisectoral collaboration as being crucial to promoting the best interests of children in Latvia. The Centre believes violence towards children can be prevented if everyone – professionals, parents, neighbours – sees the signs then chooses to act.

Parenting programmes currently being taken forward include “Pathways to competence”, “Child’s guardian angel” (or “Safe beginnings”), and “Fathers matter”.

“Pathways to competence” was developed in Canada and implemented in Latvia in 2009. The target group is parents of children aged 0–7 years and the programme is delivered through 12 2.5-hour meetings for parents in weekly sessions. External evaluations by the University of Latvia show that positive changes made by mothers in relation to reductions in depression, personal distress, negative interactions with their child and levels of parenting stress were maintained at six-month follow-up, alongside increases in self-esteem.

“Child’s guardian angel” (or “Safe beginnings”), a programme for parents of children 0–2 years old, was developed by the Centre eight years ago and is delivered in cooperation with social services. It consists of open group meetings twice a month, with parents participating with their children. Qualitative interviews with parents and social workers indicate that the programme helps parents learn important parenting skills and build social networks, sometimes to the point where children who have been taken into care can return to the family home. The programme is now delivered across Latvia.

“Fathers matter” recognizes the key role of fathers in preventing child abuse. Research by the Centre with 505 fathers found they wanted to spend more time with their children, but were facing challenges in areas such as positive parenting and knowledge of how to discipline

children without harming them. The “Fathers matter” programme has two branches (universal and targeted) that help men develop skills and recognize the shortcomings imposed by so-called traditional thinking.

The Centre has recently launched the “Child-safe and friendly preschool” programme in collaboration with the NGO SOS Villages Association Latvia, the Riga municipality and the Oak Foundation. Currently being piloted in 10 preschools, the programme acknowledges that many children from age 18 months spend up to 12 hours a day in preschools until they are 6 or 7 years. It was developed to help teachers recognize their important role in preventing child abuse and provide them with the knowledge to do so effectively. Central to the programme is promoting and protecting children’s rights through relationship-safety rules focusing on rights, boundaries, empowerment, problem-solving and skills. Currently, the programme covers 210 teachers and 3600 children a year.

Programme approaches

The workshop featured a range of programme approaches to child maltreatment prevention.

INSPIRE: seven strategies for ending violence against children

Dr Alexander Butchart, Coordinator, Violence Prevention, WHO headquarters

INSPIRE is a technical package aimed at focusing diverse players’ attention on a discrete group of evidence-based strategies and interventions. The name is an acronym for the seven strategies it presents:

- **implementation and enforcement of laws**
- **norms and values**
- **safe environments**
- **parental and caregiver support**
- **income and economic strengthening**
- **responsive services**
- **education and life skills.**

INSPIRE was developed by 10 global agencies. It brings together evidence-based practices from across the globe and deals with violence (maltreatment, bullying, youth, intimate-partner, sexual, emotional and psychological violence, and witnessing violence) in young people from 0–18 years. Six of the seven strategies described focus on prevention.

The INSPIRE vision is that governments, with the strong participation of civil society and communities, routinely implement and monitor evidence-based interventions to prevent and respond to violence against children and help them reach their full potential.

Evidence presented includes the reduction in violence and other benefits of:

- restricting access to alcohol through a range of measures (implementation and enforcement of laws);
- changing norms around intimate-partner violence (norms and values);
- so-called hotspot interventions, which involve police and emergency departments sharing anonymized information around dangerous practices that might foster teenage violence (such as the behaviours of pub and club owners) and working with the source of those practices (safe environments);

- reducing child maltreatment through the Nurse–Family Partnership (NFP) approach (parental and caregiver support);
- using conditional cash transfers that involve training programmes on issues such as gender equity to reduce intimate-partner violence (income and economic strengthening);
- reducing trauma symptoms and functional impairment through trauma-informed cognitive behavioural therapy (responsive services); and
- teaching children how to handle conflict and other issues in non-violent, pro-social ways (education and life skills).

The aim is to see continuous uptake of INSPIRE from countries. Indicators and implementation handbooks are being produced.

Parenting for Lifelong Health

Professor Frances Gardner, Centre for Evidence-based Intervention, University of Oxford, United Kingdom (England)

Parenting programmes aim to change norms and attitudes by enhancing positive parenting skills, non-violent discipline strategies and parent–child relationships, and reducing harsh, punitive, abusive parenting, child aggression and problem behaviour, and parental stress and depression. They are most effective when based on active learning and practice by parents, and have the strongest effects for families of children aged 2–10 years. Programmes can be costly, so WHO and partners set out to create cheaper generic programmes that use the same evidence-based principles.

Parenting for Lifelong Health is a collaboration involving WHO, the United Nations Children’s Fund, and the universities of Bangor, Oxford and Reading (United Kingdom), and Cape Town and Stellenbosch (South Africa). Its aims are to:

- develop and test a suite of programmes across the developmental spectrum, from babies, to children aged 2–9 years, to teenagers; and
- demonstrate rigorous evidence of effectiveness in reducing the risk of child maltreatment and improving child well-being.

Programmes are affordable and relevant, and potentially can be integrated in local services, making them sustainable and scalable. Programme materials are open-source and freely available, although delivery inevitably incurs some costs.

The programme for 2–9-year-olds was tested in South Africa and is currently being adapted for use in the Philippines and Thailand. Funding is being sought to make adaptations for central and eastern Europe. It promotes positive parenting and non-violent discipline through pre-programme home visits and 12 weekly group sessions using illustrated stories, role plays, discussions and text-message boosters, and is delivered by community-based facilitators using collaborative social learning techniques. Two randomized trials of the 2–9 programme and one for the teenage programme in South Africa have shown increases in positive parenting and reductions in harsh parenting.

The Safe Environment for Every Kid (SEEK™) model

Mr Steven Lucas, Director of Preventive Child Health Services, Uppsala University Children’s Hospital, Sweden

SEEK™ was developed in the United States of America and has been transferred to the Swedish context. A cluster randomized controlled trial (RCT) of SEEK™ in Swedish preventive child

health services has been set up to develop a universal method to identify psychosocial risk factors in the child's home environment and assist in providing supportive services for the family.

SEEK™ focuses on psychosocial risk factors behind child abuse and neglect – poverty, depression, extreme parenting stress, substance misuse and intimate-partner violence – and has four components:

- education of health-care personnel (particularly nurses) – they need to be knowledgeable about psychosocial risk factors from the outset and know what resources are available;
- completion of the SEEK™ screening questionnaire by parents;
- nurses using motivational interviewing to address issues raised in the questionnaire responses with parents, identifying any resistance to accepting help; and
- an offer being made to support a connection with services – commonly the first step is for the nurse to invite parents back for further discussion on the problem and how to resolve it, but parents can also be referred to other services and NGOs.

The third pilot study for the trial (November 2015–May 2016) involved six nurses and included a population in Dalarna county of around 20 000 children aged 0–6. Preliminary results show around 35% of parents reported problems in relation to child safety (basic questions on issues such as the parents knowing the telephone number of the poisons centre and having smoke detectors in the home), 17% money problems, 19% depression (affecting almost as many fathers, who are not routinely screened, as mothers), 19% extreme stress, 9% substance misuse and 14% current or historical intimate-partner violence. Those with problems in relation to child safety also tended to have problems in the other areas. The key point is that conventional screening does not cover all of these factors, and many parents have not previously received help for their problems.

The aim now is to scale-up the research through a two-year trial involving 34 health centres randomly assigned to control and trial groups. Children will be followed-up as they enter school.

Nurse–Family Partnership

Ms Lieke van der Meulen, VoorZorg [Nurse–Family Partnership], the Netherlands; and Ms Tine Gammelgaard Aaserud, Regional Centre for Child and Adolescent Mental Health, Norway

NFP is an early intervention targeting potentially high-risk young women (typically young expectant mothers of a first child with low incomes and living in deprived neighbourhoods with risk factors such as intimate-partner violence, previous abuse, housing problems and unemployment) from early pregnancy until the child becomes 2 years old. The programme was developed in the United States of America and has proven effective in RCTs conducted there and elsewhere.

The NFP's main aims are to improve:

- primary prevention of child abuse and serious developmental problems in young children;
- the pregnancy and birth process for mother and child;
- the health and development of the child; and
- the personal development of the mother and her opportunities for training and work.

The Netherlands was the first country in Europe to adapt the NFP through its VoorZorg programme. **Ms van der Meulen** explained that VoorZorg has six domains: the health of the mother and child; the safety of direct surroundings; the life-course of the mother; the role of the mother; the role of partner, family and friends; and community facilities. Implementation is standardized, but also flexible – it is based on trust between the mother and nurse and is very much driven by the mother. Interventions are intensive, with 40–60 home visits during the 2.5 years. All nurses involved are trained in NFP and provide a range of interventions.

An RCT of VoorZorg showed that 98% of mothers had four or more risk factors. Compared to a control group, the VoorZorg mothers showed significant reductions in smoking, smoking with the baby present, and numbers experiencing sexual, physical and psychological violence (as both victims and perpetrators). The main question of the RCT was whether VoorZorg reduced child abuse, and a significant difference was seen – 19% (31 cases from 164) in the control group and 11% (18 from 168) in the VoorZorg group. The programme is also cost–effective, with investment regained in 4–5 years.

Ms Gammelgaard Aaserud described the piloting of the NFP in Norway. Implementation is very similar to that in the Netherlands. NFP is offered in addition to usual services, but targets families most in need. NFP nurses are either public health nurses or midwives, all of whom are prepared appropriately. Interpreters form an important part of the service, and external evaluations are in place throughout the piloting phase. The aim is that the learning from the pilot will benefit not only the NFP, but also usual services, who are involved through participation in NFP's local advisory boards.



Universal services as a model of strengthening promotive and preventive services

Dr Jukka Mäkelä, National Institute for Health and Welfare, Finland

Finland does not use the NFP programme, but has an approach similar to that of SEEK™ in Sweden. It recognizes that a child needs an immense investment over a long period of dependence and development; no parents can manage on their own, and the child is at risk if parents cannot find adequate help. Providing social support is therefore a means of ensuring primary prevention of child maltreatment.

Social support can be seen as a communal way of raising children. It provides practical help at home, improves parenting by lowering the burden in other areas, and helps parents to manage their own feelings by increasing their sense of self-worth. It also presents an opportunity for multisectoral collaboration through day care, social welfare, specialist health care and police involvement. Unfortunately, some of the opportunities offered by social support of this kind have been reduced following the financial recession.

The idea is to provide support through regular meetings with nurses. Partnership is encouraged by having, wherever possible, the same nurse from pregnancy to school-age. Nurses receive training in having meaningful conversations with parents about their concerns and providing

early interventions and support. Risk factors in families are assessed, with 10–20% of families found to be in need of increased support. Typically, increased support is supplied through extra visits and home visits, peer support in parent groups (supported by NGOs) and specialist consultations.

Among the challenges faced are the need for ongoing resources to support primary prevention through universal services, finding approaches that enable fathers to participate (such as after-work time slots for groups), changing attitudes to intersectoral collaboration, and implementing methods that help those at highest risk.

Triple-P (Positive Parenting Programme)

Dr Raziye Salari, Department of Public Health and Caring Sciences, Uppsala University, Sweden

The Triple-P is a multilevel system of parenting and family support interventions based on social learning and other evidence-based theories, including public health approaches to parenting. Developed in Australia, it consists of five levels of intervention with increasing levels of intensity: parenting information campaigns (lowest intensity); brief parenting advice; narrow-focus parent skills training; broad-focus parent skills training; and behavioural family interventions (highest intensity). Delivery is in different formats to meet the needs of individuals, groups and those who pursue self-direction.

Triple P was first introduced in Sweden in 2008, following cultural adaptation. The first cluster RCT was conducted between 2009 and 2011 in 21 preschools. Preschool teachers were trained in delivering Triple-P and offered the programme universally to all parents in the intervention preschools: 29% of parents opted to participate. The average cost per child was €23, with the main component being staff training: excluding training costs reduced it to €24 per child. Challenges included the small sample size and high practitioner turnover.

Data collection for the second trial started in 2013 and is ongoing. The issue of high staff turnover is being addressed through being more selective in who is involved (meaning the staff want to take the training, rather than being assigned by their headteachers), offering ongoing support after training and encouraging staff to start using the programme early (they are less likely to use their training if they have not started the programme three months after training was completed).

Although many parents expressed interest in the programme, participation in the second trial is low, and not many fathers have taken part. Steps to market the programme to parents include normalizing parenting, highlighting the benefits and addressing the barriers to participation.

Experience to date suggests that the core components of evidence-based parenting programmes like Triple-P can be retained, but varying degrees of cultural adaptation will be necessary. Non-health professionals can successfully be trained to deliver the programmes, which may reduce training and delivery costs, although high staff turnover needs to be addressed. Successful implementation of this kind of programme at population level requires increasing target-group awareness through active marketing, and a willingness to be flexible and persistent.

The Incredible Years

Mr Bjørn Brunborg, Head of Implementation, The Incredible Years Norway; Ms Piia Karjalainen, Specialist, The Incredible Years Finland; Dr Marija Anderluh, University

Children’s Hospital, Slovenia; and Ms Anniki Lai, independent expert in social welfare and child protection, Estonia

The Incredible Years’ purpose is to improve parent–child relationships, reduce harsh discipline, increase parental social support, improve parent–teacher partnerships, promote child social competence, emotional regulation, problem-solving and school readiness, and prevent, reduce and treat social and emotional problems. Long term, the aim is to prevent conduct disorders, school drop-out, delinquency and substance misuse. Its programmes are supported by more than 30 years of clinically proven worldwide research. Programmes have been applied in more than 20 countries.

Mr Brunborg explained that The Incredible Years was first used in Norway in 1999 and has evolved significantly. Today, it consists of eight programmes for parents, children aged 3–8 and teachers. The focus varies, from an attentive parenting universal programme for parents of children who do not exhibit conduct disorder that focuses on promoting positive behaviour, to toddler and parent programmes targeted on those who show symptoms of disorder or for whom risk factors are in place, to preschool and school-age programmes for parents of children with diagnosed disorders. The programmes are cross-age and cross-settings (parents, children and classrooms) and are focused on universal prevention through to treatment for specific disorders.

Funding from the Norwegian Directorate of Health disseminated through three regional centres for children and young people’s mental health and child welfare has enabled four The Incredible Years centres to be established. The funding also enables equal access to the programmes, and free training and access to materials, supervision and consultancy for organizations. The Incredible Years works in 125 of the 426 municipalities in Norway, and 40 health-service outpatient clinics. While having a national provider with knowledge of implementation is important, local ownership is also vital.

Challenges in implementation include language barriers, which incur extra costs for translations, impose barriers for group leaders and cause delays in programme implementation. It is not an expensive programme, however, with the biggest cost being staff salaries.

Ms Karjalainen described the situation of The Incredible years in Finland. The project was brought to Finland in 2005, with the last project funding completed in 2015. The Incredible Years Finland was formed in 2012, run by volunteers.

A survey of parent group leaders’ experiences between 2006 and 2014 found that 239 people had taken part in leaders’ training, but only 85 of them, mostly social workers and psychologists in family guidance centres, had run groups. Reasons for this included the lack of an implementation strategy, structure for peer support, official guidelines, permanent funding, structure for certification (and therefore ensuring fidelity) and research, and only partial translation of materials. These leaders had nevertheless run 130 groups over the time period, with a very low drop-out rate for parents, and reported high satisfaction among parents and a good fit between the programme and Finland’s needs.

Child and family reform is currently being taken forward in Finland, including a project to develop a family centre model that will include two evidence-based programmes from The Incredible Years. It is hoped that an organization with a permanent funding base will be created to oversee the programmes. An RCT on the preschool parenting programme is underway and data are being collected from a study of early education.

Dr Anderluh said that Slovenia is new to The Incredible Years, which was piloted from March 2015 to October 2016 with support from the University of Tromsø, Norway. Ten centres were established in five regions, with more than 340 parents of children between 3 and 8 years taking part. The pilot was a multisectoral collaboration involving the health, social services and local authority sectors, alongside parents and children.

Ninety-two per cent of the parents completed the programme. Evaluations show improvements in parenting skills against the Parenting Scale in relation to laxness, overreacting and verbosity, each of which suggest positive change. Improvements in parents' well-being were also seen six months after the programme. Qualitative feedback from professionals was positive.

Future plans include establishing a multisectoral centre for evidence-based early intervention to support quality, fidelity and training, setting up 30 centres for 5–10-year-olds that will be established in the child and adolescent mental health centres and regional social services to facilitate access to the programme to around 1000 parents a year, and introducing new parts of the Incredible Years programs - the Parenting Program for school age children, Teacher's Classroom Management Program. The implementation of the programs has been supported through the partnership of the Slovenian ministries of health, education and social care.

Ms Anniki Lai spoke about the situation in Estonia. Despite barriers and some opposition, a European Economic Area-supported pilot of The Incredible Years, initiated and led by the Ministry of Social Affairs with coordination of implementation assigned to the National Institute for Health Development, ran between October 2014 and March 2017.

Thirty-two group leaders were trained (some in Estonian and some in Russian language). Fifty-two preschool basic programme groups (27 Estonian, 25 Russian) were run in 21 local government areas, with 523 parents completing the programme. For the advanced programme, 61 parents completed from five groups. Pre- and post-programme evaluation results were similar to those of other countries, with significant change in children's serious conduct problems. A cost–benefit analysis showed that €1 spent on The Incredible Years led to €14 being gained through less use of health and social services, increases in academic achievement, reductions in criminal activity and greater success in the labour market.

One of the challenges faced was that 80–90% of the parents participating in the pilot were referred by child protection officers, which presents a danger of stigmatizing the programme. This is compounded by municipalities tending to prefer targeted rather than universal approaches to support families at risk.

The strengths of the pilot include collaborative leadership from ministries, the strong planning for actions post-pilot, the start-up investment from donor funding (although it is recognized that sustainable funding has to be secured thereafter), and, crucially, stakeholder buy-in from the outset.

The KiVa antibullying programme

Dr Miia Sainio, Department of Psychology, University of Turku, Finland, and Ms Triin Toomesaar, Active Manager KiVa, Estonia

KiVa is formed from the first two letters of the words in Finnish that mean “bullying” (**K**iusaamista) and “against” (**V**astaaan).

Dr Sainio explained that KiVa started in Finland in 2006 at the University of Turku, funded by the Ministry of Education and Culture. Around 90% of schools had registered for KiVa by 2011. It builds on the theory of the participant role approach, suggesting that influencing the behaviour of bystanders is essential in bullying prevention.

KiVa is a whole-school programme with multi components. It defines universal preventive actions and indicated interventions to stop bullying, and provides monitoring through an annual survey. Teachers have manuals, and there are also online games and materials to raise awareness among students and parents. Teachers are trained to use KiVa measures to address bullying and follow-up on incidents.

The KiVa antibullying programme is evidence-based. It was first rigorously evaluated in an RCT in 2007–2009, followed by a study from the first year of national dissemination of the programme in 2009/2010. It was found to reduce bullying and victimization significantly, and also affected several other outcomes, such as bystander behaviours, students' antibullying attitudes, school well-being and academic motivation. Importantly, KiVa influenced children's perceptions of their teachers' attitudes and how well teachers were able to reduce bullying.

Key success factors include clear national policy on antibullying measures and recommendations for schools, and prioritizing of student well-being, in addition to learning. At school level, KiVa is proving successful because it includes universal and indicated actions, provides concrete tools and easy-to-use materials, and it works.

Ms Toomesaar shared the experience of implementing KiVa in Estonian schools. A group of social entrepreneurs wanted to do something about the bullying problem in Estonia and worked with an NGO to research what options were available. From this process, the decision was made in 2012 to test the KiVa programme.

A pilot was set up and an RCT comparing 20 KiVa schools with 19 control schools launched. A decrease in bullying victimization was found during the pilot year. KiVa was therefore accepted for wider implementation, but some steps were taken in the year before dissemination to prepare new and joining schools, including a preparatory seminar for headmasters. Extra training and support opportunities for teachers through, for example, web training and coaching were developed, and volunteers made regular contact with the schools to provide information and raise awareness. In addition, parents' guides and computer games that were part of the original programme but had not yet featured in Estonia were developed.

Some downturn was seen in the second year of participation, but support was offered during the third year to avoid drop-out; the benefits were seen in year four, when the average rate for bullying victimization in schools dropped from 21.5% in 2013 to 15.7%. The hope is to cover 90% of schools by 2020, including those that are Russian-speaking.

The Olweus[®] Bullying Prevention Program (OBPP)

Mr Andre Baraldsnes, Senior Adviser on Bullying and Implementation, Uni Research Health, Norway, and Ms Ieva Dulinskaitė, OBPP Senior Instructor, Lithuania

The OBPP aims to prevent and reduce school bullying by building capacity. It is a whole-school approach that includes all adults and children in schools, with trained instructors guiding progress. Generally, the programme is implemented over 18 months.

Core measures are: an annual student survey to measure prevalence and other factors; training for school instructors (12 days); study and supervision groups for all staff members, including bus drivers and canteen personnel; an improved supervisory system for breaks and school entrance and exiting times, when 60–70% of bullying occurs; simple but firm antibullying rules; parental involvement in problem-solving and capacity-building; and problem-solving routines for teachers and others. Programme fidelity is assured through quality assurance, internal and external auditing and other measures, and key elements for implementation (such as building leadership capacity, organizational readiness and training) are defined.

Mr Baraldsnes stated that similar reduction patterns in bullying victimization and perpetration have been seen across countries using the OBPP. As an example, research on the Haugesund municipality in Norway between 2002 and 2015 involving 14 schools and 5500 students saw levels reduce from just over 8% in 2004 to just below 4% in 2015. As with other programmes, annual school performance can vary, but over the long term, the pattern is one of reduction. A meta-analysis of the total number of evaluations of antibullying programmes across the world with sufficient scientific quality (24 in total) found that the OBPP was the only one that had repeatedly documented positive effects.

Ms Dulinskaitė described OBPP implementation in Lithuania since 2008, when it was discovered that 70% of students had been bullied. A search for best practices culminated in the Ministry of Education and Science signing a contract for the OBPP. Since then, 90 instructors have been trained and 370 schools have used the programme (currently 94, with 57 certified as Olweus schools).

An Olweus online survey is carried out every November in all schools in the programme, with an average 80% participation among students from grades 3–10. More than 35 000 students have taken part. As the programme duration is 18 months, five rounds of schools have been involved since 2008. Overall, the results show a 45% reduction of bullying victims between 2008 and 2016 and a 57% decrease in perpetrators. The survey also shows a rise in students' perceptions of how willing teachers are to intervene to stop bullying.

Online portal for kindergartens/day-care institutions and schools in Norway

Ms Elise Skarsaune, Directorate for Children, Youth and Family Affairs, Norway

There is great variation between how, or whether, institutions – kindergarten/day-care providers (either public, private, NGO or self-organizing) and school owners (local authorities) – educate children on violence and abuse. Children nevertheless have a right to information. They need to know what is right and normal to be able to protect themselves (and their friends) from what is not right and not normal.

The online portal, which is still being developed, aims to ensure violence and abuse-prevention training in kindergartens and schools is systematic, quality assured and consistent in quality across the country. It targets not only children, but also teachers and other staff and parents, and links to the national action plan to combat violence and sexual abuse against children and young people 2014–2017. It is a collaborative venture involving the ministries of health, education, and children, youth and family affairs.

Content will reflect a positive approach, focusing initially on teaching what is normal. It will be developed in different languages used in Norway, including Sami languages, and will present

quality-assured resources for organizing and carrying out work on children's knowledge and skills development, structured according to age groups and reflecting the requirements of pupils with special needs. Boxed text will offer teachers an overview of recommended programmes and partners in prevention, detection and managing violence and abuse, and content will also be developed for kindergarten/school owners and managers.

The process has revealed the importance of getting all actors involved early, and that developing such a resource takes time. It is also vital to communicate in sector-specific language.

PlayRoom: assessment and prevention of sexual abuse

Associate Professor Katrine Zeuthen, University of Copenhagen, Denmark

Guided by practitioners' experiences and existing research, an attempt has been made in Denmark to offer an integral and practice-oriented understanding of why the field of child sexual abuse is so difficult to understand, relate to and act on, and how this could be addressed by various professional groups. The work includes implementation of PlayRoom "Spillerum", a projective imagery project originally aimed at prevention, but also tested and developed for assessment of cases with suspicions of child sexual abuse.

The aim of PlayRoom is to implement a prevention programme supporting children's learning about relations with a focus on boundaries, emotions and psychosexuality. The preventive scope is integrated into a developmental perspective based on theory of infantile sexuality and dealing with the child's overall development, integrating the belief that children and young people should be able to discover sexuality in due time without it being articulated as something potentially threatening.

The PlayRoom method unfolds through a dialogue between a child and a practitioner well known to the child (mainly social workers, teachers and psychologists) about illustrations that convey everyday situations involving children and adults thematically distributed within five dualities: pleasure/lack of pleasure, activity/passivity, voluntariness/force, fantasy/reality and care/abuse. The purpose is to enhance children's ability to recognize, understand and express their own and others' boundaries in relation to the illustrations by strengthening the practitioner's ability to listen to, and interact with, the child.

PlayRoom has been developed in collaboration with almost 200 children from various institutions in Denmark and their practitioners. It was created for, and in collaboration with, the National Board of Social Services, a government agency under the Ministry of Children and Social Affairs, and was originally developed between April 2009 and December 2012 with a specific focus on vulnerable children at risk. At present there is a specific focus on children in day care through a targeted and intensive nationwide spreading and implementation of PlayRoom in all day cares in Denmark.

Practitioners attend a four-day course in which they learn to unfold, structure and analyse a dialogue with a child around the images, not only by listening to what the child says or observing how he or she acts, but also by listening to their own listening and observing their own observations.

PlayRoom has also been developed into an app – PlayRoom and My Own Room – and the website Mistanken.dk [Suspicion.dk] has been developed in cooperation with the National Council for Children for professionals working with children to help them understand and act on

suspicious of child sexual abuse in an appropriate way. The preventive scope of PlayRoom has been developed into an assessment tool for psychologists and is currently being used by the five national child protection centres as part of assessment of suspicions of child sexual abuse.

Breakouts and closing

Participants joined in parallel breakout discussions to focus on the NFP, parenting for lifelong health, stay safe/awareness of sexual abuse/violence in schools, and monitoring the European child maltreatment prevention plan. Key points were fed back to a plenary session before the workshop was closed.

Breakouts

NFP

1. Social support and parenting-skills training for parents is an urgent priority, as they provide the best-known means of prevention of child maltreatment and abuse.
2. Universal health assessments by public health nurses and doctors, and the support given to parents, provides help at a low threshold, but many families need much more targeted support. NFP is one of highest-intensity interventions for specific target groups, but other methods are needed for other families.
3. Collaboration would be encouraged in the Nordic–Baltic community by bringing people from countries in which the NFP has been established to the Baltic states to present to local communities, parents and politicians.

Parenting for lifelong health

1. Government support is necessary to keep programmes sustainable. WHO has a very important role in communicating with governments around programmes to encourage action.
2. Researchers also need to become skilled in speaking to politicians, particularly by communicating what is meant by cost-effective programmes.
3. Care needs to be taken to ensure programmes retain their fidelity after processes of adaptation and implementation. There is a danger that programmes may change so much during adaptation that they become unrecognizable to original developers.

Stay safe/awareness of sexual abuse/violence in schools

1. Languages are an issue when trying to transfer approaches across and within countries.
2. Approaches and programmes need to be adapted to cultural and systemic contexts. At the same time, there should be no fear about learning new things. There should also be a consciousness from the outset of how the programme or approach would fit with existing systems: for instance, could universities integrate it within their programmes?
3. Sexual abuse and violence is a heavy topic – people who are working in this area need ongoing support to survive it and keep performing effectively over time. People can become super-defensive and have difficulties communicating across sectors.

Monitoring the European child maltreatment prevention action plan

1. Prevention programmes identified at this workshop would provide valuable inputs into the questionnaire “Countdown to 2020: progress in implementing the European child maltreatment prevention action plan”.
2. A progress report to the WHO Regional Committee in 2018 would provide an opportunity to seek further political support for preventing child maltreatment.

Annex 1

PROGRAMME

DAY ONE: THURSDAY 1 JUNE 2017		
<p>09:00–09:30 Chair: Dr Aiga Rurane, WHO country office, Latvia</p>	<p>Official welcome</p>	<p>Ministry of Health of Latvia Dr Santa Livina Ministry of Welfare of Latvia Ms Līga Āboliņa WHO Regional Office for Europe Dr Dinesh Sethi, Violence and Injury Prevention Programme Nordic Council of Ministers Mr Anders Geertsen, Head of the Department for Education and Welfare</p>
<p>09:30–09:50</p>	<p>The life-course approach and preventing child maltreatment</p>	<p>Dr Dinesh Sethi, Violence and Injury Prevention Programme, WHO Regional Office for Europe</p>
<p>09:50–10:20</p>	<p>Adverse childhood experiences – the costs of doing nothing and opportunities for intervention</p>	<p>Professor Mark Bellis, WHO Collaborating Centre for Violence Prevention, United Kingdom</p>
<p>10:20–10:40</p>	<p>The INSPIRE package</p>	<p>Dr Alexander Butchart, WHO Coordinator Violence Prevention, WHO headquarters</p>
<p>11:10–11:20 Chair: Dr Jana Feldmane, Ministry of Health, Latvia</p>	<p>Video animation on adverse childhood experiences</p>	<p>Professor Mark A. Bellis Director of Policy, Research and International Development, Public Health Wales, Professor of Public Health, Bangor University</p>
<p>11:20–11:50</p>	<p>Bringing about change in Norway: national policy action to stop violence against children</p>	<p>Dr Anne Lindboe, Ombudsman for Children, Norway</p>
<p>11:50–12:20</p>	<p>Progress in Sweden in preventing child maltreatment</p>	<p>Professor Staffan Janson, Karlstad and Örebro universities, Sweden</p>
<p>13:20–13:50 Chair: Dr Alex Butchart, WHO</p>	<p>Video on child abuse in Europe followed by a survivor’s view</p>	<p>Ms Lisbeth Zornig Andersen, Huset Zornig, Denmark</p>

headquarters	on the need for prevention	
		Panel: Ms Liga Abolina , Ministry of Welfare, Latvia Dr Audrone Astrauskiene , Ministry of Health, Lithuania Dr Ola Florin , Ministry of Health and Social Affairs, Sweden Ms Asta Dilyte , Ministry of Education and Science, Lithuania Dr Freja Ulvestad Kärki , Directorate of Health, Norway Dr Pirjo Lillsunde , Ministry of Social Affairs and Health, Finland Ms Tiina Tõemets , Children and Family Department, Ministry of Social Affairs, Estonia Dr Bjarne Laursen , National Institute of Public Health, Denmark Ms Guðríður Bolladóttir , Ministry of Welfare, Iceland
13:50–14:50	Panel on multisectoral collaboration and action on how can governments respond	
14:50–15:20	Positive parenting and parenting for life-long health	Professor Frances Gardner , University of Oxford, United Kingdom
15:40–16:10 Chair: Dr Freja Ulvestad Karki, Directorate of Health, Norway	The Safe Environment for Every Kid	Mr Steven Lucas , Department of Women's and Children's Health, Sweden
16:10–17:10	Panel on implementation of Nurse–Family Partnerships	Panel: Examples from Europe and transferability Presenters: Ms Lieke van der Meulen , VoorZorg (Nurse–Family Partnerships), the Netherlands Ms Tine Gammelgaard Aaserud , Regional Centre for Child and Adolescent Mental Health, Norway Dr Jukka Mäkelä , National Institute for Health and Welfare,

		Finland
		<p><u>Discussants:</u> Dr Jana Feldmane, Ministry of Health, Latvia</p> <p>Dr Robertas Povilaitis, Director of Child Line, Lithuania</p> <p>Ms Tiina Tõemets, Children and Family Department, Ministry of Social Affairs, Estonia</p>
17:10–17:30	Implementation and evaluation of a multi-level parenting programme, Triple-P (Positive Parenting Programme) in Sweden	Dr Raziye Salari , Department of Public Health and Caring Sciences, Uppsala University, Sweden
DAY TWO: FRIDAY 2 JUNE, 2017		
09:00–09:15		
Chair: Dr Ola Florin, National Board of Health and Welfare, Sweden	Recap/debrief	All
09:15–09:45	Parenting and preschool support in Latvia	Dr Agnese Sladzevska , Center Dardedze, Latvia
09:45–10:45	Panel on The Incredible Years	<p>Panel: <u>Presenter:</u> - Mr Bjørn Brunborg, The Incredible Years, Norway</p> <p><u>Discussants:</u> Ms Piia Karjalainen, The Incredible Years, Finland</p> <p>Dr Marija Anderluh, University Children's Hospital, Slovenia</p> <p>Ms Anniki Lai, Head of the Task Force for Reducing Burden of Care, Estonia</p>
11:15–12:45	Panel on violence prevention in schools	<p>Panel: <u>KivA presenter:</u> Dr Miia Sainio, Department of Psychology, University of Turku, Finland</p> <p><u>Discussant:</u> Ms Triin Toomesaar, KiVa</p>

		Estonia
		<u>Olweus presenter:</u> Mr André Baraldsnes , Uni Research Health, Norway
		<u>Discussant:</u> Ms Ieva Dulinskaitė , Olweus Program Senior Instructor, Lithuania
		<u>Presenters:</u> Ms Elise Skarsaune , Directorate for Children, Youth and Family Affairs, Norway
		Professor Katrine Zeuthen , University of Copenhagen, Denmark
13:45–15:00 Chair: Dr Dinesh Sethi, WHO Regional Office for Europe	Breakout sessions: develop contexts for Nordic and Baltic partnerships	1) Nurse–Family Partnerships 2) Parenting for life-long health 3) Stay safe/awareness sexual abuse/violence in schools 4) Progress in evaluating the European child maltreatment prevention action plan
15:00–15:30	Plenary: feedback from the breakout session groups	All
15:30–16:00	Closing and next steps	WHO and focal points panel

Annex 2

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