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How small  
countries are  
improving health  
using the  
life-course  
approach



**How small  
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improving health  
using the  
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## Abstract

The life-course approach encompasses actions that are taken early, appropriately to life's transitions and together as a whole society and is one of the key concepts among the priority areas for policy action of the WHO European policy framework Health 2020. The Andorra Statement, originating from the Second High-level Meeting of Small Countries (2015), called for investment in health promotion and disease prevention programmes in the early stages of life because of their high economic, social, development and equity returns. Both the Minsk Declaration itself and the Resolution on the Minsk Declaration on the Life-course Approach in the Context of Health 2020 provide further support, encouraging this approach to be embraced. In 2016 the WHO Regional Office for Europe asked the small countries to share their experiences with implementing life-course actions. Issues reported on included: nutrition throughout the life-course; physical activity; overweight and obesity prevention; early childhood development; vaccines; supporting parenthood; increasing adolescent health knowledge; adverse childhood experiences; and long-term integrated health care. Countries reported that implementing a life-course approach provided an important forum for discussing the issues surrounding the disadvantaged in society, and such disadvantages can be passed intergenerationally. It is therefore important to monitor developments and consider proposals for improvements. There was overall consensus among the eight countries that life-course initiatives helped with the application of a comprehensive approach to health.

**Keywords:** DELIVERY OF HEALTH CARE, HUMAN DEVELOPMENT, LIFE STYLE, GOVERNMENT, COMMUNITY PARTICIPATION, COOPERATIVE BEHAVIOR, HEALTH POLICY.

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## **Foreword**

*I am very pleased to present this report that showcases actions taken by the eight countries of the WHO small countries initiative to promote the life-course approach.*

*The life-course approach is an essential concept for the implementation of the WHO European policy framework Health 2020 and the 2030 Agenda for Sustainable Development. Through the Minsk Declaration in 2015, the Member States of the WHO European Region committed to act early, act appropriately during life's transitions and to act together as a whole society at all stages of the life-course, at both individual and population levels and across the generations. Linked with a whole-of-government and Health in All Policies approach – and by addressing health inequalities and leaving no one behind – the life-course approach plays a critical role in improving health and well-being for all. It improves the social return on multisectoral investments for health and well-being by addressing the root causes and consequences of ill health.*

*The eight small countries in the WHO European Region (with populations under 1 million) have made great strides in this area. The country case stories of the WHO small countries initiative compiled in this report offer the reader a range of inspiring examples. They highlight on the one hand the specific advantages and challenges that small countries have in implementing health policies using a life-course approach; on the other hand, they also serve as encouragement for other countries to learn from each other by sharing good ideas, concepts and experiences.*

*In this way, we will succeed together to implement the 2030 Agenda by building on the Health 2020 policy framework.*

*As the coordinating office for the Small Countries Initiative, the WHO European Office for Investment for Health and Development congratulates everybody who has contributed to this interesting report and I wish all eight countries much success in the further implementation of their life-course programmes.*

Christoph Hamelmann  
Head of WHO European Office for Investment for Health and  
Development  
WHO Regional Office for Europe

## Abbreviations

ACEs	adverse childhood experiences
BCA	biennial collaborative agreement
CGA	geriatric assessment and management
CHPG	Princess Grace Hospital (Monaco)
COSI	WHO European Childhood Obesity Surveillance Initiative
CVD	cardiovascular diseases
EHIS	European health interview survey
ENA	Andorran National Health Survey
ENNES	National Strategy for Nutrition, Sport and Health (Andorra)
EU	European Union
GYTS	Global Youth Tobacco Survey
HBSC	Health Behaviour in School-aged Children
HEPA	health-enhancing physical activity
HiAP	Health in All Policies
IDEFICS	Identification and prevention of dietary- and lifestyle-induced health effects in children and infants epidemiological study
JANPA	Joint Action on Nutrition and Physical Activity project
MGCC	Monaco Gerontology Coordination Centre (Monaco)
NCDs	noncommunicable diseases
NGO	nongovernmental organization
OPEN	Obesity Prevention through European Network
RIIIGCC	Rainier III Gerontology Centre Clinic (Monaco)
UNICEF	United Nations Children's Fund
WHO	World Health Organization

## Executive summary

The health outcomes of individuals and the community depend on the interaction of multiple protective and risk factors throughout people's lives. Taking a life-course approach means adopting a temporal and societal perspective on the health of individuals and cohorts, as well as on the intergenerational determinants of health. It encompasses actions that are taken early, appropriately to life's transitions and together as a whole society and is one of the key concepts among the priority areas for policy action of the WHO European policy framework Health 2020. The Andorra Statement, originating from the Second High-level Meeting of Small Countries (2015), called for investment in health promotion and disease prevention programmes in the early stages of life because of their high economic, social, development and equity returns. Both the Minsk Declaration itself and the Resolution on the Minsk Declaration on the Life-course Approach in the Context of Health 2020 provide further support, encouraging this approach to be embraced.

In 2016, the WHO Regional Office for Europe asked the small countries to share their experiences implementing life-course actions. Issues reported on include nutrition throughout the life-course; physical activity; overweight and obesity prevention; early childhood development; vaccines; supporting parenthood; increasing adolescent health knowledge; adverse childhood experiences; long-term care; and integrated health care. Information collected for the case stories included the issue involved and why it was selected; the trigger(s) for action; a full description of the initiative; mechanisms facilitating the use of a life-course approach; the involvement of various sectors; overarching issues or support from specific policies; financing; and the overall impact and key lessons learned.

Most countries shared a key set of triggers for taking action using a life-course approach as a guiding principle; among these were data and evidence (national surveys, scientific research and epidemiological or demographic shifts) as well as policy and political triggers (a long-term vision, and/or the existence of national and international policy documents). Intersectoral action was reported as a fundamental component of all the life-course case stories, with the health sector as the leader and coordinator of most initiatives. The education sector was actively involved as a core partner in all country case stories.

Other players involved in implementation of life-course initiatives were the social, finance, agriculture, defence, commerce, justice, labour, public works, environment, urban development and sports sectors. Nongovernmental actors were involved in half of the reported initiatives, and the private sector (in various forms) was active in three quarters of initiatives. The media was present throughout, providing support in terms of information dissemination and health campaigns. Government – including both central and local authorities – also played an important role in initiatives using a life-course approach within the small countries.

Mechanisms that made the use of a life-course approach possible included: political commitment, the existence of relevant legislation, working groups, the availability of scientific evidence to support action, human resources, opportunities for consultation, campaigns, and availability of financing. The small country size was reported as a facilitator for action, as was the existence of national health plans or other policy documents. Lack of funding to generate more evidence, human resource constraints and communication were cited as challenges to implementation. Most countries reported some kind of evaluation taking place or in progress, ranging from partial evaluations with epidemiological studies and the collection of child anthropometrics, to separate evaluations planned for different components of the initiative.

Countries reported that implementing a life-course approach had provided an important forum for discussing the issues surrounding the disadvantaged in society, and such disadvantages can of course be passed from generation to generation. It is therefore important to monitor developments and consider proposals for improvements. There was overall consensus among the eight countries that life-course initiatives helped with the application of a comprehensive approach to health. The case stories also demonstrate how the application of a life-course approach is helping them to reach the goals and targets of the 2030 Agenda for Sustainable Development.

Key messages from the case stories can be summarized as follows.

- Thinking long term is important, including planning for the future, keeping a mindset that is life-course conscious.
- Early investments in health will provide a better foundation for a happy, strong and productive adult society in the future.

- It is important to focus on the extremely poor segments of the population, especially low-income families with children and those that might be overlooked (for example, working parents).
- It is necessary to take a broad approach, which considers the social and economic determinants of complex societal circumstances, such as those brought about by financial crisis, or migration (and the health effects arising from these).
- Granting vertical coherence across levels of governance is key to ensuring that what is done at national level is also reflected at regional and local levels.
- It is important to obtain and use good evidence to trigger implementation of life-course actions, documenting the impact of various aspects of the action (financial elements, knowledge gain and health effects) to show that multisectoral prevention is cost-effective.
- Building up a societal structure that links health workers, schools, families and communities is essential to supporting a life-course approach, along with ensuring the existence of a network of services that best respond to population needs.
- Working across sectors is key, involving stakeholders early on and throughout the process, showing stakeholders how the life-course approach provides an opportunity to take leading roles in promoting health, while at the same time reaching their own goals.
- A monitoring and evaluation system should be set up for the initiative, with process indicators and sectoral targets to ensure accountability for health. This will help ensure that the structures in place to deliver services will address actual needs.





## Introduction

This publication features a compendium of eight small country case stories on the application of a life-course approach to health. It provides the reader with a definition of what the life-course approach means; a brief overview of the scientific evidence base highlighting the benefits and importance of applying this approach; relevant political commitments; descriptions of eight case stories on life-course initiatives carried out by small countries; and an analysis of lessons learned, including facilitating factors, challenges and capacity needs. The report concludes with the extraction of a set of key messages for those who would like to embark on similar actions.

## 1. What it means to use the life-course approach and why it matters

The health outcomes of individuals and the community depend on the interaction of multiple protective and risk factors throughout people's lives. The life-course approach adopts a temporal and societal perspective on the health of individuals and cohorts, and on the intergenerational determinants of health (1). This approach encompasses actions that are taken early, appropriately with respect to life's transitions and together as a whole society. Such actions confer benefits to the whole population across the life-course, as well as to the next generations.

Early action in childhood to strengthen social and emotional learning, coping skills and improved bonds between parents and children, has been proven to create long-lasting benefits. Inequities accumulate over the life-course and often continue across generations, leading to persistent shortfalls in health and development in vulnerable families and communities (2). For this reason, a life-course approach is required to reduce the human and social costs associated with many health issues but in particular with the current burden of noncommunicable diseases (NCDs). Most serious adult diseases have long courses of development. The effects of health-damaging behaviour and environmental hazards are often not manifest until considerable time after people have been exposed to them. Furthermore, consumer influences, extensive marketing of certain products and a lack of regulation of harmful goods also play a role in the adoption of health-damaging behaviours by transmitting feelings or images of lifestyles that seem desirable to the viewer. Access to higher education and evidence-based information to make healthy lifestyle choices results in longer, healthier lives and improved well-being.

Social position is linked to health status; the lower a person's social position, the worse their health tends to be. People in disadvantaged groups and communities often experience exclusion of many types, as well as worse health than those in more advantaged social groups. Evidence on the intergenerational passing on of poverty shows that disadvantage increases with the level of deprivation (3).

Higher educational status is closely associated with a reduced likelihood of adopting health-damaging behaviours such as smoking and alcohol

abuse. Evidence indicates that risk factors for NCDs such as type 2 diabetes mellitus and heart disease start during fetal development and in early childhood. At the same time, health in older age is linked to the living conditions and actions of an individual throughout their whole lifespan (3).

Promoting good health and taking action on the social and economic determinants of health throughout the life-course lead to an increase in healthy life expectancy and longevity, both of which bring both societal and individual benefits. Children with a good start in life learn better and have more productive lives; adults with control over their lives have greater capacity for economic and social participation and living healthier lives; and healthy older people can continue to contribute actively to society.

## 2. Political support and momentum for adopting the life-course approach

In addition to the scientific evidence in support of a life-course approach, there is ample political support and momentum for adopting such an approach. The Andorra Statement, originating from the Second High-level Meeting of Small Countries (2015), calls for investment in health promotion and disease prevention programmes in the early stages of life because of their high economic, social, development and equity returns (4). It also underlines the commitment of small countries in the WHO European Region to foster best practices for the life-course approach. The Minsk Declaration (October 2015) and the Resolution on the Minsk Declaration on the Life-course Approach in the Context of Health 2020 (5) (adopted by the 66th session of the WHO Regional Committee for Europe in September 2016) urge countries to “act early, act appropriately and act together” (see Chapter 3 for a full list of the elements involved in acting early, appropriately and together).

**Acting early** encompasses a broad set of activities, including: improving maternal nutrition and breastfeeding; minimizing childhood exposure to poverty (which lowers cognitive performance); ensuring access to vaccinations; ensuring healthy environments; encouraging cognitive stimulation and performance; fostering early learning opportunities; and preventing exposure to child maltreatment.

**Acting appropriately** means empowering and supporting people through life’s transitions, such as adolescence and parenthood; providing access to basic qualifications and work skills; improving employment prospects; promoting mental health and sexual and reproductive health; and supporting healthy ageing.

**Acting together** results in producing healthy and active environments, promoting whole-of-government approaches and intersectoral action to reduce health inequities.

A comprehensive life-course approach involves actions in a variety of settings and actors encompassing the whole of government and the whole of society. Interventions that support the accumulation of health and reduce inequalities during the life-course are of a different nature and countries usually choose the ones that are the most imperative for the particular situation in the country. These interventions include promoting exclusive breastfeeding for the first six months of life, health

literacy and parenting programmes, safe school programmes, tobacco and alcohol control measures, active labour market policies and many more.

The recently agreed upon 2030 Agenda for Sustainable Development, combined with the Health 2020 policy framework provide a unique opportunity for pursuing a life-course approach to health.

### 3. Capitalizing on the know-how in the WHO European Region: case stories from the small countries

*“We are aware of equally convincing evidence which indicates that health promotion and disease prevention programmes in early stages of life are not only cost-effective, but are also investments which bring high returns in terms of economic, social, development and equity.”*

Andorra Statement, 2015 (4)

To fulfil commitments made through the Andorra Statement and initiate the process of collecting country case stories, the WHO Regional Office for Europe sent a request, through the small countries initiative network, for nomination of a country representative who could be interviewed and assist WHO in finding information on life-course approach initiatives within the country. WHO then sent the country representatives a one-page summary explaining the essence of the interview to be conducted and set up a time for the interview with each individual. To gather information for life-course initiative case stories, an interview guide was used, partially adapted from elements of three previous projects that carried out similar mapping exercises. Key areas of focus included: the issue and why it was selected; the trigger(s) for action; a full description of the mechanisms facilitating the use of a life-course approach; the involvement of various sectors; overarching issues or support from specific policies; financing; and the overall impact and key lessons learned.

Prior to initiating the interviews, country representatives were asked for permission to be recorded in order to facilitate the process of transcribing the interviews and writing them up as case stories. Everyone interviewed agreed to be recorded and the interviews were conducted either face to face or via Skype. The interviewer took notes in the interview guide, asking additional questions as needed. After the interview, the interviewer filled out a case story template using the written notes from the interview guide, and cross-checked information against the recordings to capture additional data. If gaps were noted, follow-up interviews were carried out via email to request additional information or background documents needed to complete the case story.

Issues covered included nutrition throughout the life-course; physical activity; overweight and obesity prevention; early childhood development; vaccines; supporting parenthood; increasing adolescent health knowledge; adverse childhood experiences (ACEs); long-term care; and integrated health care (see Table 1).

**Table 1. Small country case story topics**

Country	Issue/s addressed	Case story title
Andorra	Health, nutrition, physical activity	The National Strategy for Health, Nutrition and Sport (ENNES)
Cyprus	Nutrition, physical activity	Promotion of nutrition throughout the life-course
Iceland	Social welfare, nutrition	The Welfare Watch
Luxembourg	Early childhood screening	Early screening of children aged 0–4 years to detect medical, cognitive and social needs
Malta	Nutrition, physical activity	The “Healthy weight for life” strategy (2012–2020)
Monaco	Long-term care for the elderly	Care of the elderly dependent population using a single entry point and multidisciplinary approach
Montenegro	ACEs	Addressing ACEs using a life-course approach
San Marino	Childhood obesity	Tackling childhood obesity through intersectoral and life-course approach interventions

The majority of the small country case stories focused on actions that promoted the “acting early” elements of the life-course approach. “Acting together” elements were covered in three quarters of the case stories, while half of the case stories incorporated “acting appropriately” elements. Table 2 shows the specific elements covered by each country.





## 3.1 Andorra: the National Strategy for Health, Nutrition and Sport (ENNES)

### 3.1.1 What is the issue?

The ENNES (6) consists of a set of actions to promote physical activity and healthy nutrition to prevent overweight, obesity and physical inactivity in all stages of life and especially in population segments at higher risk, such as children and adolescents, the elderly, young women of childbearing age and pregnant women.

The actions include the publication of various guidelines, providing advice on nutrition and physical activity (healthy eating and staying active), for various people and their circumstances:

- the general population
- aging populations
- children, adolescents and their families; and
- during pregnancy, lactation, and early childhood.

Several events have also been held on topics related to nutrition and physical activity, including a conference in 2007 on nutrition and public health worldwide; a 2009 conference on food and health in women; and an event in 2012 looking at what can be done to prevent childhood obesity.

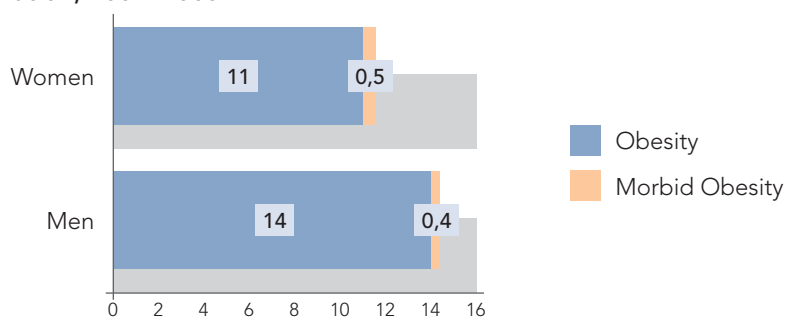
### 3.1.2 What was the trigger for using the life-course approach as a guiding principle?

The 2004 national nutrition survey (the *Enquesta Nutricional d'Andorra* (ENA)), entitled "Evaluation of nutritional status of the population of Andorra: changes in eating habits and food consumption in Andorra (1991–2005)" revealed that the population displays unhealthy eating habits, including consumption of poor-quality breakfasts and insufficient consumption of fruits and vegetables (2). Certain population groups show strong evidence of these behaviours, among which the younger population group (aged 12–24 years) consumes little fruit and vegetables, while at the same time consuming high-energy foods containing saturated fats. Young women (aged 12–24 years) also display extremely sedentary behaviour. Overall, the Principality of Andorra has a 13% prevalence of obesity and overweight in people aged 18–75 years (14.4% in males and 11.5% in females) (see Fig. 1) (2).

WHO reports show that a small number of risk factors are at the origin of, or indeed are the main cause of the significant increase in morbidity and mortality caused by noncommunicable diseases (NCDs) (cardiovascular diseases (CVD), certain cancers, diabetes, etc.), with five of them closely related to poor diet and lack of physical activity, namely:

- hypertension
- hypercholesterolemia
- low consumption of fruit and vegetables
- excess weight (overweight) and obesity
- physical inactivity
- smoking.

Fig. 1. Obesity and morbid obesity prevalence among the Andorran population, 2004–2005



Source: ENA 2004 (7).

Results from the 2004 ENA survey suggest that, although currently the population is not at extreme risk, policies aimed at higher risk population groups are warranted, with the aim of changing certain lifestyle habits to reduce future risk factors. In Andorra, a long-standing, strong tradition of collaboration between public administration and associations, private entities and foundations exists, partly owing to the country's size, which has made it easier to bring stakeholders together for a common cause. Both the public and private sectors have become aware of the nutrition situation in the country and understand the urgency of undertaking intersectoral action, involving different branches of the public administration, while also disseminating information to the public.

### **3.1.3 Description of life-course action**

This case story describes health promotion policy development aimed at disseminating information and promoting the adoption of healthy eating habits and regular physical activity.

### **3.1.4 What mechanisms have facilitated use of a life-course approach?**

The belief that healthy eating habits and engagement in physical activity must begin early in life, and continue throughout life, facilitated the adoption of a life-course approach. At the same time, early action for population groups that display unhealthy behaviours – such as sedentary lifestyles and unhealthy eating habits – can halt the progression from overweight to obesity. An intersectoral working group was formed with people from different departments within the health and education ministries.

### **3.1.5 What sectors have been involved?**

In Andorra, implementation of the life-course approach called for the participation of both the public and private sectors. The health and education ministries implemented planned activities and developed various guidelines in collaboration with the Andorran College of Dietitians. Within the health sector, the departments dealing with epidemiological surveillance, pharmacy, health products and medical facilities, and food and nutrition were engaged. The education sector received support from the departments dealing with pedagogy, youth and sport. As developing campaigns and disseminating information to the public have significant economic costs, support from the private sector was key. The private sector and the media also played an important role in the dissemination of information and activities among the population. The Crèdit Andorrà Foundation (an Andorran bank) funded publications and conferences, as well as providing logistical support and conference sites to facilitate the strategy (ENNES).

### **3.1.6 What policies or overarching issues have been key?**

International dietary and physical activity guidelines, nutrition and physical activity conferences and special national themed days

promoting physical activity – such as Sports Day for All – have been key.

### **3.1.7 How has the initiative been financed?**

Policy formulation, activities and national guideline preparation have been financed by the central Government. Funding for the dissemination of healthy eating and physical activity has been provided by a private foundation linked to a bank (Fundació Crèdit Andorrà). The annual celebration of Sports Day for All received the support of various actors, including associations and private companies. Private sponsors donated prizes and gifts to event participants, such as sports bags, T-shirts, sports clothing and shoes. In addition to funding the publications, Fundació Crèdit Andorrà provided logistical support for the organization of conferences in its headquarters or other venues, making it possible to accommodate a greater number of attendees.

### **3.1.8 What has been the impact of the life-course action?**

The year 2017 will mark the ENNES's 10th year of implementation. The Government of Andorra will carry out an evaluation to assess the strategy's impact on the population's eating and physical activity habits. A new nutrition survey is also planned and the results of it will help inform decisions about the best way to continue promoting healthy eating habits and physical activity across all population groups.

### **3.1.9 What are the key lessons learned for Andorra?**

Given the small size of the country, many of the strategy's initiatives benefited from high participation levels among the population. Sports Day for All has been held every year since 2007 and consists of regular lectures and symposia on healthy eating habits, targeting different population groups. On this day, a number of catering establishments, supermarkets, food and beverage outlets and cinemas participate in the organization and implementation of activities. To maintain high levels of participation, the involvement of the media, associations and companies from various sectors has been key. Funds are raised from the sale of marketing products, such as T-shirts, with proceeds going directly to charity organizations such as CARITAS, which works to provide help to the poor. The following publications are a selection

of those produced for Sports Day for All in Andorra:

- ENNES (the national strategy) (6);
- News item on Sports Day for All 2010 (8);
- News item on Caritas Andorra raising money through the Charlemagne Island race in 2013 (9).

### **3.1.10 Conclusions**

Further work is needed to promote healthy eating and physical activity in Andorra. The 2017 ENNES will help the country to understand not only the impact that has been achieved so far, but also the changes needed in certain activities in order to improve the health of the population, reduce health risks and related morbidity and mortality. The implementation of these actions will be strengthened and supported by declarations made within the WHO Regional Office for Europe's small countries initiative and as follow-up to the WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020 (held in Minsk, Belarus, in October 2015).

## **3.2. Cyprus: promotion of nutrition across the life-course**

### **3.2.1 What is the issue?**

This case story reports on a nutrition programme to address the growing problem of overweight and obesity in Cyprus across all of life's stages (in both childhood and adulthood). It also includes a special programme for the country's vulnerable groups. The topic of nutrition was chosen owing to high levels of overweight and obesity in the country. The economic crisis also made some groups of children more vulnerable to poor nutrition, with many eating poor-quality food or unbalanced diets.

### **3.2.2 What was the trigger for using the life-course approach as a guiding principle?**

The triggers for taking action were social, economic and evidence based. Overweight and obese individuals are unable to actively participate in society, which in turn leads to an unhealthy and less productive population, with reduced healthy life-years. The importance

of a life-course approach was already clear to Cyprus. According to the European epidemiological study “Identification and prevention of Dietary- and lifestyle-induced health Effects in Children and infantS” (IDEFICS)<sup>1</sup> conducted in Cyprus from 2005 to 2009, the prevalence of overweight and obesity in the country was 46.9% in adults (11). Cyprus also has one of highest levels of childhood obesity in Europe.

The strategic goal of the nutrition programme is to raise awareness on the importance of nutrition as a health determinant, while implementing country-wide activities that promote healthy nutrition and lifestyles. In the long term, the programme aims to reduce overweight and obesity among the general population and to introduce healthy lifestyles, while reminding people of the health benefits of the Mediterranean diet.

### **3.2.3 Description of life-course action**

Cyprus has implemented a permanent strategy and programme to tackle overweight and obesity in the country, across all age groups. The strategy was developed in 2008 when the first national nutrition plan was agreed, following the country’s results from the surveillance programme for overweight and obesity. In 2008 national nutrition guidelines for children (aged 6–12 years), adolescents (aged 12–18 years), adults and senior citizens were developed using data from the IDEFICS study as a basis, which provided one of the largest European datasets for children ranging from 2.0 to 9.9 years of age. Cyprus formed part of a cohort of 16 228 such children that was examined in a baseline population survey from autumn 2007 to spring 2008 in eight European countries (Belgium, Cyprus, Estonia, Germany, Hungary, Italy, Spain and Sweden) (6).

Based on these data, Cyprus developed a community-based programme as an overall umbrella initiative, with a programme for children and another for adults who are around 47% overweight. The nutrition programmes cover the various life stages.

1. The programme focusing on nutrition for pregnant women provides advice, dietary information and menus to pregnant

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<sup>1</sup> The IDEFICS study developed and implemented innovative community-oriented intervention programmes for obesity prevention and healthy lifestyle promotion, primarily in children aged 2–10 years in eight European countries: Belgium, Cyprus, Estonia, Germany, Hungary, Italy, Spain and Sweden (10).

women. It also features regular weight monitoring and nutritional advice according to weight.

2. The neonatal nutrition programme works through a breastfeeding promotion strategy, which provides advice and support to nursing mothers and their families. Health workers make home visits to breastfeeding women and check the newborn's weight.
3. Nutrition for school-aged children is tackled through a series of nutrition-related actions taking place in schools for the first four years of primary school and the first four years of secondary school. These actions consist of overweight assessment by means of somatometry, with referral to dieticians for nutrition advice and assessment (upon parental consent). All children from vulnerable groups are provided with a healthy breakfast, which consists of cereals, sandwiches and yoghurt. Children are offered a wide variety of options, so that they become accustomed to different flavours and foods. Twice a year, children and parents are invited to school and shown different healthy breakfast options. On other occasions, children, dieticians and cooks prepare a healthy Mediterranean lunch and invite parents to participate. Events have also taken place at Parliament, with children and members of Parliament meeting and eating a healthy meal together. Legislation exists in Cyprus to regulate school canteens, stating that products need to be sugar free and cakes made of plain (not puff) pastry, and that only freshly squeezed fruit juices are allowed, while soft drinks are forbidden in the school setting.
4. Nutrition promotion is encouraged in males enrolled in the army (all males are required to enrol in the army when they finish school). This programme offers them advice regarding healthy foods based on the Mediterranean diet and interactive lectures on health determinants.
5. Adults benefit from a number of regular nutrition awareness campaigns, live streaming and community-based campaigns, including nutrition days. These days are full of music to encourage a festive atmosphere, while a broadcasting team goes to a main street, a park or a shopping mall and transmits live on nutrition. Passers-by are asked to express themselves on the topic of nutrition and what it means to them, and health professionals are available to give advice.

6. In nursing homes, special menus are provided with age-appropriate, healthy ingredients.
7. Future parents receive nutrition information by means of an initiative offering 12 lectures to help them prepare for the parenting role, during which they also receive advice on nutrition. Participation is on a voluntary basis, with vulnerable groups and the highly educated segments of the population attending most often.

Physical activity promotion is carried out by the Cyprus Sports Organization, which developed a national strategy on physical activity. The organization also works on promoting sports among children and adolescents. Children have the opportunity to participate in sports every afternoon for a fee of about €20 for a 3-month period. Vulnerable groups are offered this opportunity free of charge.

### **3.2.4 What mechanisms have facilitated use of a life-course approach?**

The Ministry of Health of Cyprus, with a coordinating and leading role, has provided steady support to the life-course approach initiatives. A number of sectors, including education, industry and agriculture have been engaged in tackling the problem of overweight and obesity in the country. There is also a high level of political commitment, with Parliament members and the Council of Ministers approving strategies and encouraging the ongoing functioning of the programmes. Another useful mechanism is the working groups that were set up for each of the programmes mentioned; these have facilitated a comprehensive and coherent way of working and communicating. The legislation in place regulating food in school canteens has also been instrumental (see section 2.3).

### **3.2.5 What sectors have been involved?**

Aside from health sector involvement, the agricultural sector has also been involved, through a European Union (EU) financial programme, whereby the Ministry of Agriculture, Rural Development and Environment ensures that fresh fruit is provided in schools, free of charge for all children. The Ministry of Education and Culture has introduced a twice-weekly lesson on health promotion as a core subject; this lesson is delivered by introducing practical situations that allow children to



learn, providing examples of healthy lifestyles. The education sector has also been involved by cooperating with school health services to promote and assess children's health. The commerce and industry sectors have contributed by ministries financing campaigns to offer free foods (such as bread and meats) prepared without salt or of only low salt content. The Ministry of Defence contributes by ensuring army personnel are offered healthy food, and also cooperates with the Ministry of Health on health promotion programmes.

Nongovernmental entities, such as nongovernmental organizations (NGOs) related to the Cyprus Dietetic and Nutrition Association, have taken an active role in this initiative, promoting healthy foods. The Cyprus Sports Organization<sup>2</sup> set a strategic goal to increase the number of citizens involved in sports programmes and activities by 0.5% each year until 2020. The organization cooperates with schools and communities and offers sports programmes and events at low cost or free of charge. The media's health reporters have helped to move work forward and disseminate information.

The strategy and programmes have produced benefits for everyone involved. Children now have a basis from which to become healthy adults, strengthening the future of the country, and industry understands the benefits of promoting healthy nutrition and wants to show social commitment. The Cyprus Sports Organization is very keen on voluntary initiatives and believes that promotion of healthy behaviour has a long-lasting effect, whereby engaging in sports becomes a lifestyle. The organization also sees a secondary effect on the parents of children who engage in physical activity, thus ensuring a positive intergenerational effect. These benefits now extend in both directions, from children to their parents and vice versa; these children will be the future generation of adults that will grow up having engaged in sports since childhood.

### **3.2.6 What policies or overarching issues have been key?**

Aside from the legislation regulating foods in school canteens in Cyprus, no laws exist to regulate nutrition. Government policies

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<sup>2</sup> The Cyprus Sports Organization is a semi-governmental organization. Its main objectives are to develop sports outside schools (extracurricular) and coordination of sporting life in Cyprus.

exist on various issues, such as breastfeeding, and the wider issue of socioeconomic inequalities is considered with the country's monitoring of migrants and individuals of low socioeconomic status. In order to secure the appropriate use of financial assistance, the Government provides families with coupons for food that can only be exchanged in the food sector. Some communities also collect food and distribute it to families in need on a weekly basis. Vulnerable groups are also provided with coupons for children to participate in recreational activities, such as visiting amusement parks.

### **3.2.7 How has the initiative been financed?**

The Government of Cyprus has financed the initiative. An urban project (co-financed by the EU) is in place to promote walking, cycling and use of public transport. Contributions have been made in part by related industries, the church and voluntary organizations, which have offered food for the healthy breakfast initiative and the social markets. Voluntary NGOs (charities), such as "Wagon of Love" ask people in supermarkets to buy certain foods (according to a list provided) and these are then distributed to vulnerable groups. Industry has partly financed the campaign on collecting and offering healthy food for vulnerable groups. The church has also played an important role, distributing food to vulnerable families.

### **3.2.8 What has been the impact of the life-course action?**

As a result of the life-course action initiatives, a partial evaluation was carried out in 2016, by means of epidemiological studies and collection of somatometric measures.

### **3.2.9 What are the key lessons learned for Cyprus?**

Cyprus' experience adopting a life-course approach for working on nutrition attests to the country's belief that early investment in health makes for a future adult society that is happy, strong and productive. Small country size made it easy to adopt such an approach, as did close interpersonal relationships. Work around nutrition in Cyprus has received a high level of commitment from the Government, the media and the voluntary sector.

The challenges Cyprus has faced in adopting a life-course approach to nutrition have included lack of documentation in the form of independent epidemiological studies. Cyprus does not have a universal national health system nor does it have an inclusive electronic national data network; an electronic national health information system would facilitate data management. Unifying data across the public and private sectors – both of which offer health services – is challenging. Economic issues and funding for nutrition programmes remain a challenge. Reaching vulnerable groups in Cyprus, such as migrants, remains an area to continue to work on, owing to language barriers and cultural issues. Cultural mediators, provided by the Ministry of Foreign Affairs, are now being used to facilitate dialogue between migrants and schools. While high- and low-income groups are reached by most nutrition initiatives in Cyprus, the middle-income group is still not adequately covered. This population segment comprises primarily educated people who, with the availability of information on the Internet, believe they know a lot about health. Their participation in health lectures and other similar initiatives is therefore limited and represents a possible problem for public health, since it is unclear whether they are accessing or receiving the correct information. The Ministry of Health is cooperating closely with different NGOs and employers in order to increase participation of this group in life-course approach initiatives.

This experience has shown that it is important to think long-term when implementing the life-course approach to health. A plan for the future needs to be in place that involves working together and involves all stakeholders.

### **3.2.10 Conclusions**

The experience of Cyprus shows the importance of having synergy to work together towards a common target to get results. Support to data collection is needed and the health information system should be strengthened. Other countries wanting to carry out similar actions should approach health in a holistic way with a focus on prevention to protect health.

### 3.3. Iceland – the Welfare Watch

#### 3.3.1 What is the issue?

In October 2008 the financial crisis hit Iceland and the rest of the world. Banks collapsed and people were desperate, with some losing everything. In 2009, Welfare Watch was set up by the Government of Iceland with the aim of systematically monitoring the social and financial consequences of the economic situation for families and individuals and to propose measures to help households. It also made it a priority to defend the rights of those who are at most risk, including children and families with young children, disabled individuals, chronically ill people, old people living in poverty, unemployed individuals and those depending on financial assistance from local authorities.

Welfare Watch believes it is essential to maintain the provision of basic services by central and local governments, to ensure equality and proportionality in streamlining measures and to prevent measures that intend to save money from resulting in additional expenses for the government sector. The long-term vision of Welfare Watch is to tackle the difficulties arising from the financial crisis and encourage the Government to consider a broad range of measures to stimulate job creation, as well as supporting enterprises already operating to protect jobs. Welfare Watch also intends for young unemployed people to be kept active with suitable study opportunities and labour market measures.

Welfare Watch continues to exist in Iceland. In June 2014 it was reappointed as an entity (with the same function as before and) with an additional special focus on people living in severe poverty and low-income families with children. The initiative plays a critical role in monitoring the development of proposals for improving the welfare of these vulnerable groups.

#### 3.3.2 What was the trigger for using the life-course approach as a guiding principle?

The trigger for establishing Welfare Watch was the 2008 financial crisis and the effect it was having on the welfare of families with young children and at-risk groups. Ministers and the steering committee members agree that it would not have been created if it had not been for the sudden changes in Icelandic society that were seen as a result of the financial crisis.

### 3.3.3 Description of life-course action

Welfare Watch was led by the Ministry of Social Affairs and Social Security and was established as a body independent from the Government, to ensure it remained detached from the stigma associated with government in times of crisis. When it was established in 2009, unemployment in Iceland was at 8%, up from 2% prior to 2008. Welfare Watch became an advisory group for the authorities (government, local authorities and institutions). A total of 16 people were originally appointed to the group and valuable additions were made (taking the number to 19), including representatives of the social partners, interest groups, local authorities, institutions and government ministries. The advisory group also currently has two employees, bringing the total number of people involved to 21. These individuals form part of a steering group that discusses the well-being of people in the country, including what protection was needed in each situation and how to work together to find solutions.

One of the chief features of Welfare Watch has been its vigorous level of activity, through various working groups, to address the situations surrounding:

- children and families with young children;
- young people aged 15–25 years;
- individuals at risk before the financial crisis;
- unemployed people;
- health care and households' financial positions;
- survey consultancy and social indicators group;
- the basic services provided by central and local governments (specifically those provided by school health care services and social services).

This case story focuses on the work of three working groups: children and families with young children; basic services and the provision of lunch at schools for all children; and social indicators.

1. The working group focusing on children and families with young children gathered data about the position of children in Icelandic society and the effect of the economic situation on them. It stressed that information currently available should be used to develop services and formulate future policy to protect children.

It also committed to guarantee families access to professionals with an emphasis on family counselling by the health and social services sector. Comprehensive solutions were proposed, aiming to ameliorate financial difficulties faced by households, with a focus on: helping those in the greatest difficulty; assisting those at risk, who were likely to find themselves in difficulty; and supporting those who might encounter difficulties in the 1–2 years after the crisis (even if they were currently able to cope with simple measures taken by the Government and credit institutions to reduce payment burdens).

2. The working group for basic services, including provision of lunch at schools for all children was inspired by evidence from a number of studies that collectively point to a clear relationship between good health status, positive health habits and academic performance of students (12). The two areas most studied are physical activity in schools, and diet, along with the consequential academic performance. During the crisis, the Government supported a proposal from Welfare Watch to urge local authorities and school committees to take all possible measures to ensure that all children attending schools under their control would receive a daily lunch, regardless of family income. This was carried out in collaboration with the Union of Local Authorities in order to ensure its effectiveness.

The topic of food in schools was chosen because it was thought that, in a crisis, it would be important to ensure that children received at least one hot meal a day, which could be provided during school, even parents could not afford to pay for it. Today almost all children in Iceland receive lunch at school. In most schools, parents pay 58–96% of the cost but in others, lunch is free. Some schools even began offering free porridge in the morning. While no formal evaluation has been carried out, teachers have anecdotally reported that it is easier to teach and students are more “happy” when they have eaten a proper meal.

3. The working group on social indicators collected data on basic social indicators to analyse welfare trends, taking into account the social circumstances and health status of the population owing to changes in the social environment and the structure of services. Social indicators are used to formulate government policy and develop future services, and they are updated annually according to a contract between the Ministry of Welfare and the country’s statistical bureau, Statistics Iceland.

### **3.3.4 What mechanisms have facilitated use of a life-course approach?**

The 21-person steering committee was key in coordinating work, comprising representatives from (among others) ministries, government agencies, municipalities, unions and NGOs. A number of working groups were set up to deal with specific issues, touching upon different stages of the life-course, each chaired by a member of the steering committee (see section 3.3). The working groups mapped the situation, assessed the consequences of the economic collapse on the target group and made clear what information was lacking to enable a better understanding of the welfare needs of the population (and therefore the country). They then prepared a summary of what had already been done to mitigate the effects of the crisis and recommended improvements. A recommendation was made that the working groups should keep equal rights in mind at all times and examine the effects of actions or omissions on both sexes, immigrants and other minorities.

### **3.3.5 What sectors have been involved?**

Welfare Watch is staffed by representatives of various sectors connected to the welfare system, government ministries or agencies, and other entities.

Government ministries or agencies played an active part in the Welfare Watch dialogue. They were available to hear what other representatives proposed as solutions and provided responses and information. They also facilitated the work of the relevant ministries in order to benefit low-income people and those at risk.

Ministries involved were:

- Ministry of Welfare
- Ministry of Education, Science and Culture
- Ministry of Finance and Economic Affairs
- Ministry of the Interior

Government agencies involved were:

- Directorate of Health
- Centre for Gender Equality

- Directorate of Labour
- Debtors' Ombudsman
- Ombudsman for Children
- Primary Health Care of the Capital Area
- Social Insurance Administration

Local authorities took the lead in organizing the school breakfast and lunch initiatives, among these the Icelandic Association of Local Authorities and Reykjavik City Council.

Academic institutions involved were the social work department of the University of Iceland and an academic, nongovernmental family counselling organization (*Félag fagfólks um fjölskylduráðgjöf*). These had a wealth of knowledge that supported the work of Welfare Watch.

Social partners involved were the SA-Business Iceland, the Federation of State and Municipal Employees, the Icelandic Confederation of Labour, the Association of Academics and the Icelandic Teachers' Union.

Interest groups and nongovernmental actors made very important contributions because they were often in direct contact with people that were most at risk, they understood how they were being affected and could describe the reality of the situation at hand. Among those involved were:

- The Vocational Rehabilitation Fund
- Icelandic Church Aid (interest group, nongovernmental actor)
- Family Aid Iceland (interest group, nongovernmental actor)
- United Nations Children's Fund (UNICEF) Iceland (international agency, nongovernmental actor)
- Save the Children Iceland (nongovernmental actor)
- Home and School (National Parents' Association) (interest group, nongovernmental actor)
- The Organization of Disabled in Iceland (interest group, nongovernmental actor)
- National Association of Senior Citizens (interest group, nongovernmental actor)
- National Association of Intellectual Disabilities (interest group, nongovernmental actor)



- Sjónarhóll – Counselling Center (a new resource for parents of children with special needs in Iceland) (interest group, nongovernmental actor)
- Icelandic Red Cross (interest group, nongovernmental actor)
- Icelandic Mental Health Alliance (interest group, nongovernmental actor)
- The Women’s Shelter (interest group, nongovernmental actor)
- Women of Multicultural Ethnicity Network in Iceland (interest group, nongovernmental actor)
- The Homes Association of Iceland (interest group, nongovernmental actor)

### **3.3.6 What policies or overarching issues have been key?**

Welfare Watch has received high-level support from the Government. From the outset, the reduction of socioeconomic inequalities and the protection of a range of at-risk groups were considered priority areas.

### **3.3.7 How has the initiative been financed?**

Welfare Watch as an entity has been financed by the Ministry of Welfare, through the state budget. It has very low operational costs, in terms of production of reports and organizing of conferences. The specific proposals from the Welfare Watch that are agreed to be funded are financed from the relevant state or local authorities. A counterbalance fund was established for the functioning of Welfare Watch, to cover various needs, as they arise, including (among other projects):

- undertaking studies of welfare issues;
- coordinating projects carried out by NGOs;
- supporting staff working with the most at-risk population groups;
- helping to implement campaigns to assist specific groups that are most affected by economic crisis.

### **3.3.8 What has been the impact of the life-course action?**

An assessment of the work of the Welfare Watch was carried out in July 2015 (13). It showed that the organization played a crucial role

in helping to improve the situation of various groups in society who needed support. It has also been an important forum for discussing the situation of the disadvantaged in society. It is, however, still important to monitor developments and receive proposals for improvements. A survey among the members of the working groups contained questions on the extent to which the aims of Welfare Watch had been achieved. A large majority (84%) stated that monitoring the social as well as financial consequences of the economic crisis on Icelandic families and households had been successful (13).

### **3.3.9 What are the key lessons learned for Iceland?**

The direct dialogue among Welfare Watch representatives has resulted in a better understanding of the situation in Iceland in times of crisis, particularly for low-income families and those at risk. Welfare Watch representatives gained considerable knowledge about where to expect problems and how to tackle them. Government support of the work of Welfare Watch and the collaborative nature of the entity were instrumental in reducing the harmful effects of the crisis. A network such as this one can be used to foster cooperation between a broad range of stakeholders, such as ministries, government agencies, labour market partners (unions, social partners) and nongovernmental actors. Owing to the involvement of the latter, when the crisis hit Iceland, protecting the families in the weakest positions was a natural reaction. In fact, Welfare Watch became an instrument through which to join forces towards this common goal. It has also strengthened conviction about the importance of not forgetting to look at the life of children in a holistic way. since a large part of their daily life takes place in school settings. This makes it imperative that school authorities ensure that the schools take care of all children, including their nutritional needs during school hours, regardless of parental income.

Welfare Watch faces the challenge of making itself more visible and presenting its findings in a clear and organized manner. This could be done by disseminating information to reach a wider audience. Welfare Watch would like to focus its role on developing new proposals and following them up in practice. The organization now comprises about 35 people and has made several new proposals, mostly focusing on extremely poor people and low-income families with children. It will also be necessary to focus more on the consequences of the financial crisis on both genders.

### **3.3.10 Conclusions**

Welfare Watch has been a role model for the Nordic countries. For this reason it was decided that the 2014 Icelandic Presidency of the Nordic Council of Ministers would establish the 2014–2016 Nordic Welfare Watch, a three-year research project which aims to strengthen and promote the sustainability of the Nordic welfare systems by promoting research and increasing collaboration and the exchange of experience and knowledge between the Nordic countries. The project aims to: find ways of measuring and monitoring citizens' welfare; investigate how well Nordic welfare systems are prepared for various crises; study the effects of financial crises and the consequences thereof on Nordic welfare systems; and continue to contribute to informed policy-making in welfare matters.

## **3.4. Luxembourg: screening of children aged 0–4 years for detection of medical, cognitive and social needs**

### **3.4.1 What is the issue?**

This case story describes a screening programme for early detection of conditions with potentially long-term effects on a child's cognitive development and socialization, which parents may encounter in a child's early life. The programme has been in existence for more than three decades in Luxembourg, spanning many governments. In the long term it is expected that all children will be screened to enable them to have the same start in life, regardless of parental social or economic status.

### **3.4.2 What was the trigger for using the life-course approach as a guiding principle?**

The trigger for this programme was the need to detect and address these issues early in life to ensure maximum impact. While children are assessed from birth to age 4 years, they can be followed up through to age 18 years, if needed.

### **3.4.3 Description of life-course action**

The early screening programme for children was developed by the Ministry of Health in the 1960s, and each individual component of it

has been phased in at different times. The first encounter with the programme takes place in the hospital (entry point), and children are screened and offered services for:

- detection of hearing (in place since 1968) and language difficulties
- vision (in place since the 1960s)
- vaccine administration (in place since the 1960s)
- psychosocial support for children and families (in place since 2000)
- detection of rare genetic diseases (in place since 2015).

The hearing component was introduced by means of specific legislation on hearing and vision.

#### **3.4.4 What mechanisms have facilitated use of a life-course approach?**

Use of a life-course approach has been facilitated by availability of sufficient staff to run the programme and offer services. The Ministry of Health has set up an optic service comprising 15 people who go into the field to check children's vision. The hearing component was introduced by means of specific legislation for hearing and vision. There is also an audiophonic service run by Ministry of Health personnel. All services are free of charge for children.

#### **3.4.5 What sectors have been involved?**

The sectors involved have predominantly been government ministries, with the Ministry of Health taking the lead in the overall coordination of the programme. The Ministry of Family, Integration and the Greater Region provided social support to families facing psychosocial problems or other issues and also took a leading role in examining environmental conditions related to the social aspects of the home environment and their effects on the lives of individuals. The Ministry of National Education, Children and Youth set up special schools (logopaedic centres) for children from preschool age through to 12 years old. The Ministry of Social Security financed parts of the programme that could not be funded from other sources, such as vaccinations and blood tests for rare diseases.

Nongovernmental entities have also been involved, such as parents' associations, which have been active in the educational component of

the programme in schools to ensure that the special health needs of their children are taken into account. The private sector (private health professionals) was also involved offering their services to complement to what was already being offered. For example, a child with a hearing problem can be referred to otorhinolaryngology and a surgical procedure can be undertaken to resolve the problem.

#### **3.4.6 What policies or overarching issues have been key?**

This programme has benefited from a high level of support from the outset. It is guaranteed for all children in Luxembourg, even if they are not citizens (5000 children are born in the country each year). Legislation and government policy have provided a further guarantee of the programme's continuity, with all spheres of government confirming that the different programmes should continue. The ophthalmology and audio components are backed by legislation coordinated by the Ministry of Health, which calls for all children's hearing and vision to be checked by the time they are 30 months of age.

#### **3.4.7 How has the initiative been financed?**

This early screening programme is financed by the central Government.

#### **3.4.8 What has been the impact of the life-course action?**

An evaluation is in progress.

#### **3.4.9 What are the key lessons learned for Luxembourg?**

Luxembourg can attest to the fact that an early screening programme for children is possible if a wide range of sectors and stakeholders are involved. Luxembourg is a small country with only few stakeholders, so implementation of such a programme is easier than in a country with a large population. The psychosocial component is relatively new and features a comprehensive programme for addressing these issues. Overall the programme offers concrete solutions to families upon completion of the various screenings and assessments; however, outsourcing of private professionals has been very expensive and has disrupted the harmony of the programme. Dealing with parental fear of child stigmatization from either screening results or subsequent special

follow up programmes offered to the child is a challenge that remains for the country.

### **3.4.10 Conclusions**

A country should only embark on such a programme if they have solutions to propose to families after assessments and screenings have been carried out. When implementing a multi-component programme such as this one, it is also essential to have a long-term vision mapped out.

## **3.5. Malta: the “Healthy weight for life” strategy (2012–2020)**

### **3.5.1 What is the issue?**

Overweight and obesity are increasingly a problem for Malta across the entire population. This issue has been a priority for the country since the WHO European Ministerial Conference on Counteracting Obesity (held in Istanbul in 2006) (14). Malta’s obesity strategy, entitled “Healthy weight for life”, targets the whole population to address the growing problem of overweight and obesity in the country throughout life’s stages (15).

### **3.5.2 What was the trigger for using the life-course approach as a guiding principle?**

The life-course approach was chosen as a guiding principle for this strategy. Scientific evidence shows that early interventions to prevent obesity – starting in the preconception stage and running through childhood – have a high impact later in life. The high levels of overweight and obesity in the Malta across all age groups called for an approach to tackle overweight and obesity early on in life.

### **3.5.3 Description of life-course action**

“Healthy weight for life” is a two-pronged umbrella strategy, using a risk-based approach to focus on prevention of obesity for the whole population, targeting people who are already overweight to prevent them from becoming obese as well as those that are already obese. A wider project on social determinants of health is also under way under

the “Healthy weight for life” strategy, involving the education, housing and the employment sectors.

A special focus on school children is enabled through the Maltese policy entitled “A whole school approach to a healthy lifestyle: healthy eating and physical activity policy” (2015) (16), which provides schools with an outline of the main aims, along with specific objectives and targets to be achieved. The whole-school approach targets pupils, staff and the entire community surrounding schools. The life-course approach has also been utilized by the country through other strategies, including updating of the Food and Nutrition Policy and Action Plan for Malta 2015–2020 (2014) (17) to focus on wider nutrition action for obesity and NCDs. In 2015 an updated version of the breastfeeding policy was also outlined.

There are a number of other projects resulting from the “Healthy weight for life” strategy that touch on different stages of the life-course.

1. A “Kinder” project for children aged 3–5 years focuses on nutrition, physical activity, oral health and assertiveness. A teacher training toolkit has been developed so teachers can apply new skills in the classroom setting. This project is being implemented in all schools.
2. A primary school lunchbox programme features opportunities for children to develop cooking skills, providing recipes to guide parents on what kind of foods to provide their children for lunch. The involvement of children in food preparation is highly encouraged and the lunchbox programme is supported by an ongoing TV and radio campaign. Information sessions are held so that parents and children can learn about healthy foods. Children are involved in interactive sessions, whereby learning is achieved through drama, with a set of recurring characters (a girl, a boy and a chef serving as mascots) that impart knowledge using theatre.
3. Secondary schools have focused their attention on school shops selling snacks (“tuck” shops) and promoting the selling of healthy foods in these settings. Tuck shops now receive a list of permissible and impermissible foods and external audits are carried out by environmental health inspectors to assess compliance. Secondary schools are also implementing the Obesity Prevention through European Network (OPEN) project (with a focus on deprived areas) (18). Within the OPEN project, adolescents were asked what kind of physical activity they wanted to do and both sexes chose dance

sessions. As a result, adolescent students can now engage in mass movement sessions during their class breaks and peer leaders have been identified to continue the programme.

4. The working population benefits from initiatives with employers whereby they receive advice and can attend talks, cooking sessions and weight management classes. In 2016, Malta launched food-based dietary guidelines for adults using a visual of a plate instead of the traditional food pyramid. Adults also have access to community-based initiatives that offer cooking skills classes, weight management programmes, lifestyle clinics and a variety of sports activities, such as (among others) swimming, water aerobics and Pilates. These initiatives are possible thanks to intersectoral collaboration with the education and sports ministries.
5. The elderly population in Malta benefit from relevant initiatives in rest homes, such as implementation of dietary guidelines in daily meals and talks focusing on healthy foods for their age group. Physical activity sessions are also offered and they can attend talks on healthy lifestyle in day centres.

#### **3.5.4 What mechanisms have facilitated use of a life-course approach?**

A number of working groups have been set up to facilitate development of the “Healthy weight for life” strategy. The first to be set up ensured that all principal stakeholders were identified. Working groups were also established for minor stakeholders and to involve specific target groups. Prior to the launch of “Healthy weight for life” in 2012, work was already in place laying the foundations for the strategy, and evidence-based literature reviews were carried out in preparation for its activities. Emphasis was put on early interventions, parental involvement and community interventions, as evidence shows that these factors influence childhood obesity. A legislative instrument for healthy lifestyles has also been developed in Malta, focusing on a life-course approach. An intersectoral committee has been set up to provide advice to the Minister for Health on actions relating to lifestyles (see Box 1).

The ongoing “Healthy weight for life” strategy is based on the life-course approach and uses various mediums (such as TV, radio, social media (Facebook), web banners and community outreach) to work towards its goals.



### Box 1. Legislation to support the life-course approach in Malta

The Healthy Lifestyle Promotion and Care of Non-communicable Diseases Act was passed in January 2016. The purpose of this act is to establish and ensure an interministerial lifelong approach favouring physical education and healthy balanced diets for a healthy lifestyle reducing the level of NCDs throughout all age groups.

An Advisory Council on Healthy Lifestyles has been established, comprising:

- a chairman nominated by the Prime Minister
- a public health consultant, nominated by the Prime Minister to act as Secretary to the Council
- ministry representatives from the following sectors:
  - health
  - finance
  - social policy
  - sports
  - local government
- home affairs.

The Advisory Council will meet at least once a month to deal with specific matters related to healthy lifestyles. They will provide the Minister for Health advice on:

- any matter related to healthy lifestyles;
- policies, action plans and regulations intended to reduce the occurrence of NCDs among the general public.

The Council will also:

- encourage an interministerial approach to issues related to physical activity and a healthy lifestyle;
- encourage a lifelong approach – from intrauterine life until old age – to physical activity and a healthy lifestyle.

After consultation with the Advisory Council, the Ministry may make regulations to give better effect to the provisions of the Act, with regard to:

- education and promotion of healthy lifestyles and physical activity for people of all ages, from intrauterine life to old age;
- food consumption in and around schools;
- investment in and expenditure by local councils to promote healthy lifestyles;
- nutritional quality of food consumed in institutions licensed by public authorities, including (but not limited to) old people's homes and day centres;
- an integrated approach to the promotion of food for healthy lifestyles;
- regulation of marketing of products which may have adverse effects on healthy lifestyles;
- any other issue related to the achievement of the promotion of healthy lifestyles.

### **3.5.5 What sectors have been involved?**

While the health sector (Ministry for Health) took a leading role, it also allowed space for ownership by other sectors. The health sector chairs the implementation groups of the “Healthy weight for life” strategy with other stakeholders. The central Government (namely the Prime Minister and Minister for Health) provided full support to lifestyle change through the development of legislation promoting the life-course approach and the setting up of an advisory council on healthy lifestyles, led by the Ministry for Health. The Ministry for Education and Employment, key for implementation of the strategy in school settings, was given ownership of the “Kinder” project and led the development of a toolkit capitalizing on the sector’s skills, along with the health sector’s input on nutrition. The sports sector has been actively involved in supporting the population by promoting health-enhancing physical activity (HEPA) opportunities across all ages. The Ministry for Finance was involved in recommendations for budget submissions and various incentives, such as tax subsidies on gym equipment and nursery subscriptions. The Ministry for Home Affairs and National Security played a key role in the development of relevant legislation (see Box 1).

Education and health authorities were also instrumental; they involved tuck shop owners by asking them to communicate their challenges in providing healthy foods, as well as advice on how to improve the nutritional quality of foods they offered. They also provided tuck shop owners with training on the permissible and impermissible foods, and a variety of options for foods which could be served. Restaurants were also encouraged to develop a monthly healthy meal. The media took the lead in the “Healthy weight for life” campaign dissemination, together with various NGOs and associations.

### **3.5.6 What policies or overarching issues have been key?**

The “Healthy weight for life” strategy has received high-level support from the Government of Malta from the outset. The Minister for Health launched the strategy and ongoing campaigns. The aforementioned legislation provides further support, by specifically addressing healthy lifestyles, NCDs, and a special focus on the life-course approach.

### **3.5.7 How has the initiative been financed?**

Activities have been financed through direct budgets (e.g. the health budget was used for obesity and NCDs; the education budget for school activities; the sports budget for physical activity, and so on). There has been no input from public–private partnerships, only in-kind contributions, such as free fruit distribution. Funding was also obtained through EU projects such as OPEN (18) and the Joint Action on Nutrition and Physical Activity (JANPA) (19).

### **3.5.8 What has been the impact of the life-course action?**

Separate evaluations are planned for each initiative, using a before-and-after questionnaire, along with process and outcome indicators. The lunch box campaign receives feedback directly from children. An evaluation of the mass movement in schools programme, conducted as part of the OPEN project (18), found that 55% of adolescents had become more physically active as a result of this initiative; thus the programme had managed to change behaviours (16.6% of the previously inactive adolescents were now physically active on a regular basis).

While Malta has generally decreases in overweight there has been a shift into more obesity among young children. There has also been an overall decrease in total overweight and obesity in adolescents. Results from the 2014 European Health Interview Survey (EHIS) for adults showed that 34.4% were pre-obese and 25.3 were obese (20).

### **3.5.9 What are the key lessons learned for Malta?**

Malta believes in the importance of having good evidence as well as committed people on board. The availability of scientific evidence and solid, reliable data made it clear that overweight and obesity were a problem for the country. Working groups allowed for links between different areas and fostered good relationships with other entities, which facilitated work being carried out. Stakeholders should be engaged as early as possible in the process and this could be done by holding focus groups in schools in order to engage children, parents, and school staff. The target group should also be engaged in planning (and throughout the process) by bringing together those involved in sports and those who usually do not exercise, and by inviting people to community gatherings. A system that allows for monitoring and

evaluation is also key. The fact that Malta is a small country, in which it is easy to get in contact with each other, facilitated the building of relationships with key people. It also made it possible to develop a relationship with the public, demonstrating to them that they are being cared for at every stage of life.

Limited resources are always a hindering factor; every effort is therefore being made to seek options, such as cooperation with other entities and participation in EU-funded projects. In Malta, Health in All Policies (HiAP) is still a challenge to implement. In some sectors (such as education and sports) it is easy to collaborate, but in others, working together is more of a challenge. Malta is slowly starting work with the food industry, discussing reformulation; however, because around 80% of food in the country is imported, it is still highly dependent on the international food sector.

### **3.5.10 Conclusions**

Malta believes that using a life-course approach makes sense. Proof exists that it works, and that specific people can be targeted at specific points in time and in specific settings. “Healthy weight for life” has provided an opportunity to identify times when it is best to intervene (such as adolescence, for example). More resources, especially financial support, are needed to expand on the actions being taken. It is expected that support for HiAP will increase with legislation and with growing support from higher authorities in various settings. Countries wanting to carry out similar actions should obtain evidence, and track it in order to stay up to date. Evaluation should be considered throughout the process; experiences should be shared; and tools developed should be disseminated.

## **3.6. Monaco: care of the elderly dependent population using a single entry point and multidisciplinary approach**

### **3.6.1 What is the issue?**

This case story reports on care of the dependent elderly population in the Principality of Monaco. The strategic goals of this initiative are to:

- provide home-based support to the elderly for as long as possible;
- facilitate the life of the supporting relatives;

- take care of the elderly in case of loss of autonomy;
- maintain a high level of care for the elderly.

The long-term vision of this initiative is for elderly residents to be able to access various structures that offer them services, as soon as the need arises, to ensure appropriate care is provided.

### **3.6.2 What was the trigger for using the life-course approach as a guiding principle?**

Monaco, like most European countries, is facing a growing ageing population, among which some people are no longer independent. A total of 23.67% of the population are aged over 65 years (21); for this reason, Monaco found it necessary to think ahead and develop an integrated system for the provision of gerontological services to address the growing need for care of this segment of the population, as well as their families.

### **3.6.3 Description of life-course action**

A network of geriatric services has been in place in Monaco since 2003. It aims to care for the elderly, while providing support to close relatives through a set of means and structures offering home support for as long as possible, or medical or semi-medical support when home support is no longer possible. Non-hospital and hospital-based structures are available, including nursing homes.

#### **Non-hospital structures**

The Monaco Gerontology Coordination Centre (MGCC) was created in 2006 as an initiative of the Government of Monaco in order to cope with elderly people's current and emerging needs. This socio-medical centre provides a one-stop-shop for all people over the age of 60 years living in Monaco with physical or cognitive decline, as well as for those aged under 60 years with early cognitive decline (early dementia).

The MGCC identifies people's needs by carrying out a comprehensive geriatric assessment and management (CGA), which takes place at the person's home. The result provides a bio-psycho-social and environmental assessment that allows individual needs to be identified and a personal care plan to be set up. The CGA permits systematic

screening for cognitive decline, with possible referral to the Memory Centre (within the Rainier III Gerontology Centre Clinic (RIIGCC)). The MGCC maintains close links with the Memory Centre, which carries out more in-depth assessments and early diagnoses. This ability to react allows the person and the family to anticipate decisions and the future loss of autonomy. Families are also provided with information on home medical structures and financial assistance.

Regular follow-up is carried out at the person's home by a multidisciplinary team and a close link has been established with the RIIGCC and Monaco's municipal social services, which offer meals on wheels, home care and domestic assistance, panic buttons for emergencies, and so on, thus allowing for a continuum of care between the person's home and the hospital or nursing home.

The Speranza-Albert II Centre for day care was created in 2007 and aims to help people who have Alzheimer's disease or other cognitive disorders. Each person receives an individual, multidisciplinary care plan, which is reassessed annually to adjust it according to the patient's needs. Once or twice a week, various activities are proposed to maintain social links, stimulate memory, prevent cognitive decline, improve people's self-confidence and provide opportunities for physical exercise. The day care centre aims to maintain the patient's cognitive abilities and social inclusion, by means of workshops and the provision of temporary respite to family caregivers.

## Hospital structures

Hospital structures come under the umbrella of the Princess Grace Hospital (CHPG), which offers medical, surgical, obstetric and psychiatric departments. The Rainier III Gerontology Centre Clinic and the two nursing homes, called "Résidence du Cap-Fleuri" and "A Qietüdine" fall within the hospital structures.

The Rainier III Gerontology Centre Clinic opened in February 2013, comprising 210 beds and services, including those listed here.

- An acute care geriatric department accommodates patients from their homes, from other hospital departments of the CHPG, as emergencies or for scheduled hospital stays. This service has a direct link with home care services, the mobile geriatric team and other relevant teams from the geriatric network. It allows global support and care of elderly patients with multiple pathologies.

- A follow-up and rehabilitation care unit offers temporary accommodation for the elderly, who need monitoring after medical hospitalization, surgery or other care, in order to facilitate returning home.
- A cognitive behavioural unit is available for short- or mid-term hospitalization for patients with behaviour disorders, or for those who need hospitalization for diseases but who cannot be cared for within conventional settings or departments.
- Long-term care units accommodate elderly patients with permanent total disability, chronic diseases and those at the end of their life, who need considerable long-term medical care and support.
- Geriatric consultations offer quick, expert advice, redirection to the relevant part of the geriatric network, comprehensive geriatric assessments and information about transition from home to home for the elderly.
- The Memory Centre carries out diagnosis and neuropsychological testing, medical imaging and biological reporting, as well as offering care and early support consisting of gerontological, psychiatric, neurological, neuropsychological, speech therapy and ergo-therapeutic care, provided by a multidisciplinary team.

The RIIGCC was conceived as a living centre with life plans, entertainment and cultural activities, designed to support nursing staff in their duties. It works in close partnership with the MGCC, the Speranza-Albert II Centre for day care and the A Qietüdine and Résidence du Cap-Fleuri nursing homes.

### **Nursing homes (retirement homes)**

The A Qietüdine nursing home provides 70 beds in individual bedrooms. It accommodates elderly people with a moderate loss of independence and who, based on their health status, do not need to be in a hospital or medical residence. The home provides services adapted to each patient's needs. Medical appointments and medical care are provided by private physicians and nurses.

The Cap Fleuri Residence offers 88 beds. While the living quarters and care provided are similar to A Qietüdine, this nursing home caters to permanent totally disabled elderly individuals, who may be dealing with cognitive disorders, such as dementia. It is currently in process of being totally rebuilt and modernized.

Monaco also has two private assisted-living facilities belonging to the Hector Otto Foundation, both of which accommodate elderly people, who have a moderate loss of independence but are able to carry out daily living activities.

#### **3.6.4 What mechanisms have facilitated use of a life-course approach?**

Monaco has a policy in place for improving the quality of care for the elderly and to support close relatives. The goal of the policy for the elderly is to give them a high level of care by adapting according to their level of dependence. The RIIGCC is at the core of a large gerontological project initiated by the Government of Monaco in 2003.

#### **3.6.5 What sectors have been involved?**

The Ministry of Health and Social Affairs has taken the lead in setting up the gerontological network. The Ministry of Public Works, the Environment and Urban Development took the lead in terms of infrastructure. The Ministry of Finance and Economy participated in drawing up the medical structure budget. A (semi-private) health insurance company and the Municipality of Monaco have also been involved in the network, and the media played an active role in helping to disseminate knowledge of structures and institutions to the public.

The health sector is also responsible for assessing the individual needs of the elderly and providing an appropriate individualized response accordingly. It was also the main repository of information for the integrated geriatric care system (statistics on elderly status) and its involvement was critical in the development of specific structures and their capacity (services, beds and staff), with the Ministry of Health and Social Affairs coordinating with other ministries and relevant departments.

#### **3.6.6 What policies or overarching issues have been key?**

Care for the elderly is a high priority for the Government of Monaco and is supported by specific policy.



### **3.6.7 How has the initiative been financed?**

The Government of Monaco partly finances the initiative. Care for the elderly is fully or partly financed by elderly dependent individuals or their families, but the individual centres also have their own budgets, enabling any remaining deficit to be financed with government funds, where necessary. The amount of “autonomy benefit”<sup>3</sup> per individual is calculated according to the degree of loss of autonomy and their financial resources.

### **3.6.8 What has been the impact of the life-course action?**

An evaluation is carried out every year, based on data collected from both the medical and non-medical structures. According to the MGCC personal care plans, the day care centre and home help services have delayed admission of elderly patients to nursing homes by up to eight years. Thanks to development of this system, the average age of elderly dependent people with home support has been prolonged to 84 years (along with the highest life expectancy in the world). It has also been an indisputable source of help for the close relatives of the elderly.

### **3.6.9 What are the key lessons learned for Monaco?**

The involvement of multidisciplinary team has led to the success of this gerontological network. The existence of a gerontological service that includes suitable transport, social restaurants (provided by the Municipality of Monaco), companies that provide home help, social events, and (private sector) domestic help has also facilitated the network’s functioning. Provision of data and information to the network concerning the elderly and regarding (knowledge of) the evolution of the loss of physical and cognitive autonomy have helped with coordination, and partial financial coverage of the structural deficit by the Government of Monaco has made it possible to expand the network to offer nursing home facilities. In terms of quality of care delivered, and oversight, the designation of a doctor responsible for the whole gerontological network – who also coordinates doctors in the retirement homes – has also been of great advantage.

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<sup>3</sup> In Monaco, elderly people are provided with a so-called autonomy benefit (*prestation d'autonomie*) by the Government.

In the case of the RIIGCC, it was a challenge to find free buildings and to build the necessary structures near the CHPG, where all the medical services are situated. Another challenge has been thinking ahead, with regard to the best care to provide to people in order to stop or slow down the progression of emerging diseases affecting the elderly population (such as Alzheimer's).

### **3.6.10 Conclusions**

This initiative has confirmed to Monaco the importance of analysing the emerging needs of the elderly in order to create and to adapt appropriate structures in the country (the establishments discussed have an occupancy rate of close to 98%). The advantage of a single entry point into the system has proved to be successful (having existed for 10 years in Monaco). Closely established links between the whole gerontological network have allowed for continuity of support between the place of residence and the hospital or geriatric care centre. Other countries seeking to set up a similar network should consider the importance of analysing the specific emerging needs of the elderly population in the particular country, in order to be able to offer individualized assistance plans. Close relatives should receive information and support to be able to place the elderly person in the most suitable care structure or establishment for their needs. Care of the elderly dependent population should be centralized in one geographic location, with a single point of entry into the system.

## **3.7. Montenegro: addressing adverse childhood experiences (ACEs) using a life-course approach**

### **3.7.1 What is the issue?**

There is strong scientific evidence on the short- and long-term health and social consequences of ACEs. Whether owing to child maltreatment (child sexual, physical, emotional abuse or neglect) or household dysfunction (inter-parental violence, parental separation, parent or household member alcohol and drug misuse, incarceration or mental illness), ACEs are very common but are largely undetected unless community surveys are conducted. These adversities affect physical and emotional health and, later in life, have negative implications on school performance and employment. They are also linked to a higher likelihood of developing health-harming or risk behaviours (e.g. unsafe

sexual practices, smoking, alcohol and drug misuse, self-harm), leading to poor health outcomes later in life, including NCDs, mental illness and increased risk of being a perpetrator or victim of violence. ACEs are proof that what happens in early childhood has an effect on a person's adult trajectory, and they are influenced by social determinants of health, such as deprivation and socioeconomic inequality. The effects of ACEs are cyclic; those with higher exposure to such adverse experiences are at higher risk of exposing their own children, thereby perpetuating cycles of violence and inequality.

This case story reports on a strategic approach being developed by Montenegro for the prevention of ACEs. Surveys undertaken in European countries have confirmed the high prevalence of ACEs and their strong associations with health-harming behaviours, and research shows that evidence-based programming can prevent them. Tackling ACEs could help in reducing inequalities in health and well-being, providing long-lasting intergenerational benefits.

### **3.7.2 What was the trigger for using the life-course approach as a guiding principle?**

A survey carried out in Montenegro in 2012–2013 among first-year university students showed that the prevalence of ACEs had been very high in childhood: physical abuse (24%), sexual abuse (4%), emotional abuse (30%), emotional neglect (27%) and physical neglect (19%), witnessing the mother being treated violently (24%) and alcohol misuse (12%) were all cited as common experiences. The results also showed a strong association between ACEs in childhood, mother's education level and current health-harming behaviours. Having experienced four or more ACEs, compared to having a childhood without ACEs, increased the likelihood of smoking (by 2.7 times), being a problematic drinker (10.4 times), using illicit drugs (10.4 times), having multiple sexual partners (1.8 times) and attempting suicide by 138 times (22). The survey revealed that mother's education was a determinant of whether children experience ACEs or not and thus had a big impact on children's future behavioural and health outcomes. Socioeconomic determinants of health, such as employment, mother's education and gender all have an influence on exposure to ACEs and worsening inequalities.

A life-course approach was chosen to deal with this issue, owing to the scientific evidence available that shows the effectiveness of: acting

early to provide safe nurturing relationships, preschool education and safe schools where life skills are taught, as well as living in communities in which social norms support positive discipline rather than violence. Such preventive action needs to be taken in early childhood and be sustained throughout childhood in order to reduce the likelihood of child maltreatment and other adversity. These early interventions can have considerable impact on preventing toxic stress in the child, and the subsequent cognitive and behavioural changes which lead to health-harming behaviours and mental and physical ill health in later life, ranging from self-harm to NCDs. Furthermore, childhood should be recognized as one of the key stages in a person's life, when a complex interplay of social, economic and environmental factors takes place, determining behaviours, health outcomes and overall development into adulthood and later in life. It is important to acknowledge the value of incorporating ecological considerations into the prevention framework, to highlight the need to address the social inequalities that may cause ACEs. Delivery of integrated, effective services in a continuum – rather than through separate and sometimes fragmented policies – is a must.

### **3.7.3 Description of life-course action**

Montenegro is one of a handful of countries in the WHO European Region that decided to address ACEs with a specific strategic response. Some action on protecting children was already under way in the country, but with no specific focus on ACEs. The country took an evidence-based approach to tackling the problem, undertaking a survey, with WHO support, to understand the extent of the problem. The survey showed that ACEs were a frequent problem affecting children in the country. Part of the current National Action Plan for Children 2013–2017 is based on evidence collected through the aforementioned survey on ACEs (2012–2013) as well as other international evidence.

### **3.7.4 What mechanisms have facilitated use of a life-course approach?**

Support for initial work on the strategic response came from WHO and the Ministry of Health. A multidisciplinary working group was established to conduct the ACE survey, with a number of consultations held within the health sector. These were valuable for development of methodology and survey instruments.

When the ACE survey was carried out and results became available, representatives of different sectors and other United Nations agencies, including UNICEF, were invited to a high-level consultation, at which it was made clear that this was not only a human rights issue but also an important public health issue. Strong agreement and political consensus were reached and the ministries of health, justice, labour and social welfare united in the aim of working on a strategic response, not only for protecting but also for preventing ACEs.

A policy/desk review was then carried out for ACE prevention measures which informed national consultations on strategy development. The draft strategic response was jointly developed by WHO and an intersectoral sectoral working group comprising representatives of the health, education, welfare, and justice sectors, the ombudsperson's office, the police and NGOs. It was later presented during a national policy dialogue and at a high-level meeting between the Deputy Prime Minister, various ministers and United Nations agencies (including WHO and UNICEF) to raise the profile of ACEs and the necessity of their prevention.

### **3.7.5 What sectors have been involved?**

The main sectors involved in development of the strategic response were health, education, labour, justice and social welfare. The health sector played a coordination role, gathering and disseminating scientific evidence on the prevalence of ACEs in Montenegro and actively engaging other sectors. In doing so they also realized that they would have to change their language to engage stakeholders. The Ministry of Labour and Social Welfare became actively engaged in focusing their efforts on the child protection component, while acknowledging the importance of their contribution to preventing ACEs in partnership with the health, education and justice sectors.

### **3.7.6 What policies or overarching issues have been key?**

The Government of Montenegro has given this initiative high-level priority and its full support. The Ministry of Labour and Social Welfare committed to communicating this strategic document to the Government for adoption. The main sources of international support for the development of the strategic response were WHO documents (presented on various occasions, including the Regional Committee)

and technical consultations with WHO, which influenced policy-makers to assess the magnitude of the problem in Montenegro. Public support was obtained by means of UNICEF's active outreach to civil society. In collaboration with UNICEF, a multisectoral protocol has been established, involving the social, education and health sectors, to carry out common actions to prevent early abandonment of children. These activities have been inserted into the primary health care system in order to recognize families at risk, follow up with children up to 3 years of age, and improve hospital-level information systems to better communicate with and support families at risk.

The strategic response builds on the National Action Plan for Children 2013–2017, which aimed to tackle violence against children and views it as an integral phenomenon that can be prevented, recognized early and adequately treated in order to prevent traumatic experiences and the far-reaching consequences of them on both the physical and mental health of children. The National Strategic Framework on Prevention and Protection of Children from Abuse and Neglect (2015–2019) builds on the National Action Plan for Children. Further support for work on prevention and protection from ACEs comes from Montenegro's *Master plan of the development of health system in Montenegro 2015–2020*, the country's main strategic document within the health sector, featuring a new activity that calls for ensuring that primary health care addresses violence against children and family violence, while obliging physicians to report cases. There is also a commitment to engage in primary prevention, involving cross-sectoral commitments which consist of preschool education; home visits; primary care and parenting support for families; promoting violence-free schools; education in schools to teach children to recognize signs of abusive behaviour; enforcement of bans on corporal punishment; intensive welfare; and parenting support to at risk families.

### **3.7.7 How has the initiative been financed?**

The development of the strategic response has been financed by the Government of Montenegro, with the financial and technical support of WHO Regional Office for Europe through biennial collaborative agreements (BCAs). Montenegro's Institute of Public Health has provided in-kind contributions for general participation in and support to develop the strategic response.

### **3.7.8 What has been the impact of the life-course action?**

As the strategic response was due to be adopted at the end of 2016, no evaluation is available at the time of writing. A change in mindset has taken place within the health sector, and this is also gradually being understood in other sectors involved. For quite some time, health sector representatives have realized they will need to change their rhetoric and language depending on to whom they are speaking. When they began dialogue with the education sector, they realized that tackling the problem together would help advance the agendas of both sectors, because fewer ACEs would result in better performance in schools as well.

### **3.7.9 What are the key lessons learned for Montenegro?**

Montenegro realizes that if the life-course approach is to be applied to an issue, all sectors need to be involved as equal partners, not only at the beginning of the process but considering the impact of an action throughout all of life's stages. Working on ACEs has affirmed that there are no sustainable solutions for complex challenges impacting life's different stages, without bringing in other sectors, and that every stage of life is equally important. ACEs also highlight the urgency of acting fast and early, and that considering the impact of socioeconomic determinants of health matters very much, regardless of life stage. This example also shows how much prevention matters. The ACE survey showed that if action is not taken early to prevent adversities in early childhood, the disease burden increases and physical, mental, emotional, health is impaired, along with educational attainment and employment prospects, and ultimately societal development. It successfully argues that multisectoral prevention is a cost-effective public health solution.

Political will played an important role in addressing the issue of ACEs in Montenegro (the first of seven countries that embarked on this exercise and carried out such a survey, committing its own in-kind resources). The evidence-based approach was a facilitating factor that strengthened the work undertaken. Such evidence has been made accessible through the European report *Implementing child maltreatment prevention programmes: what the experts say* (23) and given a collective voice through *Investing in children: the European child maltreatment prevention action plan 2015–2020* (24). Montenegro strives to continue to comply with the protection of human and child

rights and to address the issue of violence in the country. Challenges foreseen are those related to implementation and support for this. A better understanding of the problem across the different sectors is needed, along with more capacity for knowledge transfer to policy-makers and stakeholders.

### **3.7.10 Conclusions**

A strong multisectoral process is needed to carry out complex but necessary life-course actions for issues such as ACEs. This initiative helped policy-makers understand that scientific and practical evidence must be gathered and action taken based on concrete facts and figures, particularly in resource-limited environments. It has also reiterated the importance of working together to reach the highest levels of government and achieve consensus around health issues.

## **3.8. San Marino: tackling childhood obesity through intersectoral and life-course approach interventions**

### **3.8.1 What is the issue?**

In San Marino about 30% of children are overweight or obese. For this reason, an initiative was undertaken seeking to reduce overweight and obesity among school children in San Marino by promoting good nutrition to set the foundation for a healthy life. It also aims to ensure pregnant women and their families adopt healthy nutrition practices throughout pregnancy and know how to breastfeed and later introduce complementary foods to their children. From a broader perspective, the initiative also aims to work within communities as well as in an intersectoral capacity to create a culture that takes advantage of San Marino's potential in terms of natural resources and food. In the long term, it is hoped that all policies in the country will take health into consideration.

### **3.8.2 What was the trigger for using the life-course approach as a guiding principle?**

National data on overweight and obesity in the country (25) served as the main trigger to implement life-course action on this issue. The recently adopted national health plan, which takes a 360 degree view of the person at the centre of the system and in society, shows San Marino's commitment to work holistically and throughout the life-course.



### 3.8.3 Description of life-course action

This case story describes a set of intersectoral actions that form part of San Marino's national health plan for 2015–2017 (26). The strategy is implemented through the subsequent national programme of work for 2016, adopted on March 2016 by a Congress resolution.

Life-course approach actions pertaining to this initiative in San Marino consist of the following interventions.

1. **Prenatal** courses are available, including nutritional advice during pregnancy and information to families on healthy lifestyles, nutrition and breastfeeding. Special training on breastfeeding promotion for hospital and field-based health workers is also offered.
2. **Postpartum** support is offered to families through a multidisciplinary network consisting of midwives and psychologists that carry out home visits to newborn children and families. Home visits are carried out by psychologists in case of postpartum depression. Breastfeeding is supported through two annual 20-hour courses for health professionals, taught by WHO-certified trainers (a UNICEF and WHO initiative). With regard to nutrition, from the third month of life, parents take courses on the introduction of complementary foods to infants and at this time, the child also undergoes a full examination to assess weight, height and neuromotor function. This is also the time to discuss with the family appropriate ways of introducing complementary foods. At the seventh month, child development and complementary feeding are reviewed.
3. Nutrition for **school-aged children** is supported in San Marino through to age 10 years, with initiatives carried out by paediatricians in preschools and primary schools. A multidisciplinary and intersectoral education and health working group coordinates all nutrition issues pertinent to schools. The school canteen plays an important role in child nutrition and is supported by many initiatives. School canteen menus follow a set of criteria established by health professionals, who also assess quality and nutritional content. Teachers and cooking staff also play an important role by incorporating an educational component and minimizing food waste. A canteen committee occasionally assesses the suitability of meals and the amount of leftover food. Meetings with parents are also held, to obtain feedback on school canteen food and services and to engage them in finding solutions to any arising

issues. Parents are also able to test foods and provide feedback on quality, including sociocultural issues concerning school menus and any specific health problems affecting school-age children (e.g. gluten free, vegetarian or other special diets). Cooking staff are trained to prepare different meals for specific health needs. Schools make active links with associations that can utilize leftover food, distributing it to lower-income family households in neighbouring regions.

With regard to social well-being, personalized assistance plans are created for children with medical conditions, bringing together school teachers, the paediatrician and the parents, to ensure the child is supported in a holistic manner. This has a significant impact on building up resilient communities.

Surveillance of overweight, obesity and eating disorders are also carried out in schools through OKkio alla SALUTE (25) (part of the WHO European Childhood Obesity Surveillance Initiative (COSI) project). Teacher awareness is also raised in order to enable them to identify overweight and obese children so they can be referred to a paediatrician for informal discussion. Teachers are also asked to observe the eating habits of children and work in close contact with paediatricians to allow any nutritional problems to be identified early. To encourage physical activity among children, meetings are held with sports associations to motivate them to get involved in both competitive and non-competitive sports.

#### **3.8.4 What mechanisms have facilitated use of a life-course approach?**

The Republic of San Marino has implemented a Permanent Observatory on the Condition of Youth. By means of collaboration between the Health Authority,<sup>4</sup> health services, the Department of Education of the University of San Marino and the Mental Health Unit, the observatory

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<sup>4</sup> The Health Authority for Authorization, Accreditation and Quality of Health Services is the technical arm of the Ministry of Health and Social Security, Family, National Insurance and Economic Planning and is in charge of drawing up the national health plan and the annual national programme of work. It is responsible for: the institutional accreditation of public and private health facilities; international relations and international cooperation; and cross-sector interventions relating to health promotion and health education, involving the health, social and education sectors.

is engaged in systematic surveys in schools, using surveillance systems promoted by WHO to monitor health risk behaviours, food and tobacco consumption. Related to this, in 2013 the Republic of San Marino set up a multidisciplinary and intersectoral education and health working group to plan and coordinate health promotion and education activities in schools, with the aim of strengthening intersectoral collaboration and interventions. The participatory processes developed through intersectoral interventions contribute to the development of empowerment and social cohesion and promote social equity at all stages of life.

### **3.8.5 What sectors have been involved?**

Key players in promotion of the life-course approach were the Ministry of Health and Social Security, Family, National Insurance and Economic Planning, and the social sector (also within the health ministry). The Ministry of Education, Culture and University, Scientific Research, Social Affairs and Gender Equality (specifically, schools and the multidisciplinary and intersectoral education and health working group) facilitated communication with teachers, children and parents and the creation of a common language among sectors. The health ministry took the lead, in partnership with the education ministry. Parent associations and their representatives have been involved at various levels of schooling, along with sports associations interested in nutrition among children and adolescents, encouraging them to engage in sports activities. Through a supermarket chain, the private sector has financed information brochures for OKkio alla SALUTE and provided support to the activities of the multidisciplinary and intersectoral education and health working group. Another private sector group, the "Terra di San Marino" agricultural consortium, contributed to the multidisciplinary and intersectoral education and health working group by organizing workshops for school children on the various products they produce. In future the private sector may support the multidisciplinary and intersectoral education and health working group by contributing to organizing debates and awareness-raising events open to the public.

### **3.8.6 What policies or overarching issues have been key?**

An agreement between San Marino and WHO, entitled "Strategic

platform for investment for health and development for small-population countries" (27) and the country's national health plan for 2015–2017 (26) have been key support mechanisms for this initiative. The national programme of work for 2016 (adopted by a resolution of Congress), in which life-course approach initiatives have been actively supported, also endorsed the approach. Existing mechanisms to build upon included the multidisciplinary and intersectoral education and health working group, and the Permanent Observatory on the Condition of Youth.

Thus far, the initiative has enjoyed a moderate level of support from the Government. The long-term aim is to raise awareness among political stakeholders of the importance of overweight and obesity, to improve political commitment and to strengthen interventions that promote resilient communities.

### **3.8.7 How has the initiative been financed?**

The initiative has been financed by the central Government, with contributions from the private sector, resulting in (for example) printing a brochure to convey information to the public on the OKkio alla SALUTE surveillance system.

### **3.8.8 What has been the impact of the life-course action?**

Data from paediatric reporting from San Marino from 2014 (26) show that 70% of women in San Marino continue to exclusively breastfeed for up to three months, having received these interventions. School-based initiatives are monitored by school-based systematic surveys, using surveillance systems promoted by WHO.

- OKkio alla SALUTE (25) is a survey carried out every two years to monitor food consumption, child overweight and obesity. Data are collected for children in their third year of primary school in San Marino (about 300 children), in collaboration with Italy.
- The Health Behaviour in School-aged Children (HBSC) (28) survey is carried out regularly to monitor health risk behaviours.
- The Global Youth Tobacco Survey (GYTS) (29) monitors tobacco consumption in youth and is carried out every four years.

### 3.8.9 What are the key lessons learned for San Marino?

This case story highlights the importance of supporting parenthood at all stages and building a social structure and network between health workers, schools and families that did not previously exist, to continue to support childhood and parenthood. It also speaks to the need to pay close attention to vulnerable groups, such as children with specific health conditions, to ensure that services addressing their needs are offered. This could be carried out through home visits provided by multidisciplinary teams that assess social problems and offer support to families.

The existence of the national health plan has provided a clear political vision, supported by government legislation. The national health plan is a reminder to reassess which services respond to the needs of the population, such as those resulting from epidemiological and social changes (for example, the increase in the elderly population, chronic health conditions and the economic crisis, which has resulted in social vulnerability).

The multidisciplinary and intersectoral education and health working group has helped to eliminate the tendency to work in silos and allowed sectors to work together for a common cause. It has also facilitated the carrying out of structured coordinated actions to improve nutrition, with a long-term vision, beneficial to all sectors and stakeholders involved. In this context, small country size has made it easy to build relationships, even informally, which adds further support to this work.

San Marino acknowledges the importance of creating a network of services that respond well to population needs. While the population is supported from preconception through pregnancy and up to age 10 years, there are still segments where overweight and obesity are not being monitored systematically. Reaching adults and children aged over 10 years remains a hurdle. In the current context, these two segments of the population are not comprehensively covered, owing to the fact that most interventions are setting dependent (e.g. in schools, health centres, at home) and opportunities for detection of overweight and obesity diminish for those not regularly attending these places. It is recognized that nutrition needs for 13–17 year-olds should be addressed, since they are undergoing rapid changes, but interventions have not yet been developed for this age group. No direct population-wide interventions exist for adults, either. As a

result, overweight and obese adults and children aged over 10 years are offered mainly curative care by means of referral to dietitians who can sensitize them or their families to the risk of NCDs. Another challenge not to be underestimated is the shortage of staff (resulting from human resource constraints), preventing further work from being accomplished.

### **3.8.10 Conclusions**

San Marino believes that an integrated approach – taking into account life’s phases and corresponding needs – allows for the development of sustainable interventions, focusing on the person and their community of reference, starting from childhood and adopting a life-course approach. Further training is needed on how to apply a life-course approach to the whole population, while always involving different sectors.

The actions described in this case story provide an example of intersectoral work that foresees both short- and long-term results. In the short term, involving civil society and the social, educational and health sectors in concrete issues of mutual interest promotes equity in health, starting from childhood, with a life-course perspective. In the long term, developing cross-sectoral working tools and approaches contributes to greater social and community cohesion.

## 4. What did we learn?

Central governments provided high-level political support to initiatives, developed legislation promoting the life-course approach and, in some cases, set up advisory councils, for example on healthy lifestyles and other issues. Local authorities took the lead in organizing events about nutrition in schools, coordinating canteen meals and ensuring coherence of the approach from local to national levels.

### 4.1 What triggered use of the life-course approach?

Most country case stories shared a key set of triggers for taking action using the life-course approach as a guiding principle. These can be grouped under two categories: (i) data and evidence triggers, and (ii) policy and political triggers.

#### 4.1.1 Data and evidence triggers

- Data from national survey results, showing information on sedentary behaviours, increases in prevalence of obesity or exposure to ACEs triggered many countries to take action.
- Scientific evidence on early childhood interventions provided motive to adopt a life-course approach by showing their significant positive impact.
- Epidemiological and demographic shifts in the societal fabric, such as high obesity levels and an increasing elderly segment of the population, also motivated countries to think in the long term about health effects that could arise later in life from unhealthy behaviours in early childhood.

#### 4.1.2 Policy and political triggers

- Overall, many country initiatives recognize that a long-term vision is necessary and realize the need to detect and address conditions that could potentially have a long-term effect on a person's cognitive development and socialization.
- The existence of national policy documents, such as frameworks or health plans, as well as international impetus (for example, provided by Health 2020 and the Ministerial Conference on the Life-course

Approach in the Context of Health 2020) provided further support to using a life-course approach.

## **4.2 Intersectoral action and the life-course: sectors involved and their role**

Central governments provided high-level political support for initiatives, developed legislation promoting the life-course approach and, in some cases, set up advisory councils (for example on healthy lifestyles and other issues). Local authorities took the lead in organizing nutrition events at schools, coordinating canteen meals and ensuring coherence from local to national levels.

### **4.2.1 Health**

In all case stories, the health sector (usually through the health ministry) played a coordinating role, while allowing space for ownership by other ministries. The health sector played a significant part in assessing health interventions for the given objective and provided issue-based responses when collaborating with other sectors. It also served as an information repository, often gathering and disseminating scientific evidence on a given issue to other partners.

### **4.2.2 Education**

The education sector (again, often the ministry) was a core partner in most case stories. The role ranged from one of cooperation to engagement (for example, engagement of schools in health-related services). In some initiatives, the education sector took the lead in project components and even provided the physical setting for interventions, such as school breakfasts and lunches, while also promoting physical activity and nutrition education. It was also instrumental in creating a common language among sectors and within schools, facilitating communication with teachers, children and parents. In countries in which a working group was formed, this sector was often a key player, actively involved in the decision-making processes, and such involvement led to (for example) changes being incorporated in school curricula, development of toolkits for implementing nutrition interventions in schools, and setting up logopaedic centres to support children needing extra help.



### 4.2.3 Other ministries

The social sector<sup>5</sup> provided support to the child protection components of projects and (in some countries) financed parts of programmes that were not funded by other means, such as vaccinations and blood tests for rare diseases. Finance ministries played an important role in drawing up budgets related to life-course initiatives. They also made recommendations for budget submissions in support of programmes and, in some cases, provided incentives such as tax subsidies on equipment and subscriptions related to life-course approach interventions.

In a few countries carrying out nutrition-related life-course actions, the agriculture ministry played an important role to ensure that fresh produce was provided in school settings, free of charge. In another country focusing on nutrition-related life-course actions, the defence ministry played an important role, ensuring that recruits were provided with healthy foods in line with the country's strategy to tackle overweight and obesity. Commerce ministries contributed by financing campaigns to offer free foods such as low-salt breads and meats to schools. Family affairs ministries provided social support to families facing psychosocial problems or other issues. Justice ministries were involved in ensuring strategic responses being developed by countries on various issues were in synergy with existing or forthcoming legislation. Within the context of seeking to relieve the effects of the 2008 financial crisis, in one country the labour ministry sought to ensure young unemployed people were kept active, with suitable study opportunities and labour market measures. Elsewhere, the Public Works, the Environment and Urban Development sector played a role in identifying key infrastructure for initiatives. The sports sector was a key player in the development of national strategies on physical activity and in advisory councils on healthy lifestyles, as well as providing financing to support and promote sports among children and adolescents. In one country this commitment included setting up a strategic goal to increase the number of citizens involved in sport activities, while in another, children and adolescents were targeted and vulnerable groups encouraged to participate in physical activity free of charge.

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<sup>5</sup> The generic term social sector is used since, in each country, their work was carried out under the auspices of different ministries. At times, this fell under the health ministry and at others, it such work was carried out by the welfare ministry.

#### 4.2.4 Nongovernmental actors

A range of nongovernmental actors, in the form of NGOs, were involved in over 50% of the life-course initiatives presented in the case stories. Their role and contribution was varied. In one country, a sports organization committed to supporting the life-course approach by establishing a target to increase the number of citizens involved in sports activities (looking ahead to the year 2020). The same type of entity in another country made it possible to offer sports programmes and events at low cost or free of charge. Social partners, interest groups and NGOs working on social and health issues and having direct contact with people most at risk, had the advantage of being able to provide a real perspective of how people were being affected by a given issue. NGOs also played an important role in disseminating information generated by various issue-based campaigns. Parents' associations in some countries contributed to the development of educational components in schools.

The private sector was involved in three quarters of the life-course initiatives, with support provided by individual professionals, entities and companies in a variety of ways. In a few case stories, private health professionals provided their services to complement what was already offered, to alleviate the lack of human resources in a given subject area. Elsewhere, health insurance companies played a role in health service delivery. In one country, a supermarket chain financed the production of information brochures related to obesity, while in another, a private agricultural consortium organized workshops for school children to raise awareness on the nutritional quality of products they produce. The private sector also was instrumental in disseminating information about initiatives and engaging the public, across all case stories, and in most initiatives, it financed campaigns and information materials or publications. In one country, the food industry committed to improving the nutritional quality of foods provided in snack shops, while restaurants provided coherence to national initiatives on healthy nutrition by developing and promoting a healthy meal each month.

The media provided support to initiatives in just over a quarter of the life-course initiatives presented, with their role manifest through support from health reporters and active dissemination of information, often fundamental to ongoing campaigns. Academic institutions were also instrumental in providing scientific support to one of the eight life-course initiatives.

Table 3 shows the sectors involved in the various life-course initiatives in the eight countries.

Table 3. Sectors involved in life-course initiatives by country

Country	Academic institutions	Agriculture	Defence	Central Government	Commerce	Education	Family affairs	Finance (economy)	Health	Interior	Justice	Labour	Media	Nongovernmental actors*	Private sector	Public Works, Environment Urban Development	Social	Sport
Andorra																		
Cyprus																		
Iceland																		
Luxembourg																		
Malta																		
Monaco																		
Montenegro																		
San Marino																		

\* Nongovernmental actors include NGOs but exclude the media and the private sector.

### 4.3 Mechanisms that made the use of a life-course approach possible

Diversity of sectors was mentioned as a valuable contribution to making it possible to adopt a life-course approach in countries. High levels of political commitment and the existence of legislation (either regulating specific settings, such as school canteens or legislation relevant to the life-course approach itself) also facilitated use of this

approach. Most countries reported the establishment or utilization of already existing working groups as enablers within their settings. Sometimes this took the form of multisectoral working groups, which coordinated health promotion, or steering committees with representatives from ministries, government agencies, municipalities, unions, NGOs and working groups, set up with a specific mandate. Availability of evidence-based literature and policy/desk reviews carried out, along with the use of existing policies, also made easier the initiation of the work on implementing a life-course approach. The existence of data that spoke to the issue at hand from national surveys also contributed to the body of evidence, helping to make the case for taking a life-course approach at national level. Sufficient staff to run the programmes and offer services was reported as being key to carrying out most life-course initiatives. Events such as multidisciplinary consultations and issue-based campaigns were invaluable in engaging sectors and raising public awareness.

Financial mechanisms to support life-course initiatives reported by countries included government financing, private-sector contributions and in-kind support from scientific institutes. Nongovernmental funding came from industry, churches and NGOs. One country received WHO support by means of BCAs, which initiate work in the country on a given issue and provide technical guidance. Some countries also reported obtaining EU funding for specific components of life-course initiatives. So-called one-pot funding by means of a counterbalance fund for the operational costs of the entity managing the life-course initiative – including the financial cost for reports and arranging conferences – was reported by one country. This fund could also be used in case of the need to fund studies relevant to the initiative and to hire staff working with the most vulnerable segments of the population.

#### 4.4 Facilitating factors

Small country size was reported by most countries as a factor that made it easy to implement a life-course approach, since small countries have fewer stakeholders and everyone knows each other. A high level of commitment from governments and strong political support of the issue were also reported as being essential. The existence of national health plans and other policy documents providing clear political vision also contributed to work progressing naturally, and some countries reported on legislation, a decree or government act

making specific reference to the life-course approach. Existence of intersectoral working groups with stakeholders from different sectors and disciplines working towards a common goal was also effective for many countries. Working groups provided a forum for direct dialogue among sector stakeholders, resulting in a better understanding of the situation at hand. Support from the media and the voluntary sector was reported by most countries as being invaluable.

#### **4.5 Challenges**

Lack of funding to carry out epidemiological studies in order to provide the necessary evidence was mentioned as a shortcoming, along with the need to set up national electronic health systems. Funding was an overall area of concern, ranging from specific mentions of the need for an increased budget for health promotion to shortage of staff and the subsequent costs of outsourcing of private professionals. Communication was raised as an area that needs more support; specifically, how to make work visible, following up on work plans and proposals, and how to present findings in a clear and organized manner. Linked to this was the need to allow sufficient time to carry out life-course actions and see results.

With regard to issues and approaches, life-course initiatives might have worked better had it not been for parental fear of stigmatization of their children. Countries reported that they still actively face the issue of reaching vulnerable groups effectively, as a result of either language or cultural barriers. Some countries emphasized the challenge they faced in reaching children aged over 10 years, owing to the fact that school system structure did not facilitate the same contact with pre-adolescents, an important but neglected group. HiAP was reported by some countries to be a challenge to implement. Working with the private sector was not always easy, owing to various economic interests. Thinking ahead was also noted as a challenge to be faced, to be able to deal with emerging diseases that will most affect the population in the future.

#### **4.6 Evaluation of life-course approach initiatives in countries**

Most case stories reported some kind of evaluation in progress. Some reported partial evaluations being planned, consisting of epidemiology studies and the collection of child anthropometrics. Other countries

reported planning separate evaluations for different components of the initiative (i.e. early child development screening of school children), with one country in the midst of a 10-year evaluation. Other surveys were used to assess life-course approach initiative elements, such as “OKkio alla SALUTE”, the HBSC survey and the GYTS. Anecdotally, some countries reported that the life-course initiative had provided an important forum for discussing the issues surrounding disadvantaged people in society (which can be passed from generation to generation), allowing developments to be monitored and proposals for improvements received.

## 5. Key messages

There was overall consensus among the eight countries that the use of various life-course initiatives had resulted in the application of a more comprehensive approach to health. As can be seen in the country case stories, the life-course approach has been used and should be further promoted as a means to reaching the goals and targets of the 2030 Agenda for Sustainable Development. Countries have the conviction that every stage of life is equally important and each stage impacts the subsequent one. The key messages from the initiatives are summarized here.

- Thinking long term is important, including planning for the future and keeping a mindset that is life-course conscious.
- Early investments in health will make for a happy, strong and productive adult society in the future.
- It is important to focus on the extremely poor segments of the population, especially low-income families with children and those that might be overlooked (for example, working parents).
- It is necessary to take a broad approach, which considers the social and economic determinants of complex societal circumstances, such as those brought about by financial crisis, or migration (and the health effects arising from these).
- Granting vertical coherence across levels of governance is key to ensuring that what is done at national level is also reflected at regional and local levels.
- It is important to obtain and use good evidence to trigger implementation of life-course actions, documenting the impact of various aspects of the action (financial elements, knowledge gain and health effects) to show that multisectoral prevention is cost-effective.
- Building up a societal structure that links health workers, schools, families and communities is essential to supporting a life-course approach, along with ensuring the existence of a network of services that best respond to population needs.
- Working across sectors is key, involving stakeholders early on and throughout the process, showing stakeholders how the life-course approach provides an opportunity to take leading roles in promoting health, while at the same time reaching their own goals.

- A monitoring and evaluation system should be set up for the initiative, with process indicators and sectoral targets to ensure accountability for health. This will help ensure that the structures in place to deliver services will address actual needs.



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The life-course approach encompasses actions that are taken early, appropriately to life's transitions and together as a whole society and is one of the key concepts among the priority areas for policy action of the WHO European policy framework Health 2020. The Andorra Statement, originating from the Second High-level Meeting of Small Countries (2015), called for investment in health promotion and disease prevention programmes in the early stages of life because of their high economic, social, development and equity returns. Both the Minsk Declaration itself and the Resolution on the Minsk Declaration on the Life-course Approach in the Context of Health 2020 provide further support, encouraging this approach to be embraced. In 2016 the WHO Regional Office for Europe asked the small countries to share their experiences with implementing life-course actions. Issues reported on included: nutrition throughout the life-course; physical activity; overweight and obesity prevention; early childhood development; vaccines; supporting parenthood; increasing adolescent health knowledge; adverse childhood experiences; and long-term integrated health care. Countries reported that implementing a life-course approach provided an important forum for discussing the issues surrounding the disadvantaged in society, and such disadvantages can be passed intergenerationally. It is therefore important to monitor developments and consider proposals for improvements. There was overall consensus among the eight countries that life-course initiatives helped with the application of a comprehensive approach to health.

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