World Health Organization

REGIONAL OFFICE FOR Europe

Case studies

The WHO European Health Equity Status Report Initiative

Health & Health Services

Health & Income Security and Social Protection

Health & Living Conditions

Health & Social and Human Capital

Health & Employment and Working Conditions

World Health Organization
REGIONAL OFFICE FOR Europe

Case studies

The **WHO** European Health Equity Status Report **Initiative**

Address requests about publications of the WHO Regional Office for Europe to:
Publications
WHO Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen O, Denmark
Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (http://www.euro.who.int/pubrequest).

Edited by Ashley Craig
Book design by Marta Pasqualato
Printed in Italy by Grafiche2am

Contents

Acknowledgements vii

Introduction 1

Development of an action plan on the provision of equitable access to water supply and sanitation in Armenia 3

Achieving gender equity by sharing experiences: the Gender Equality Map in Melbourne, Australia 7

Gender budgeting in Austria: systematically improving equity between women and men 11

Partnerships for youth employment in the Commonwealth of Independent States, Azerbaijan 15

Enhancing social protection and inclusion for children in Bosnia and Herzegovina 19

Boys and Girls Clubs of Calgary: the Infinity Project 23

Effective health promotion for people at risk of poverty and social exclusion in Czechia 27

The Danish pension system: preventing elderly people from falling into poverty 31

Reducing co-payments in Estonia through information technology solutions 35

The basic income experiment in Finland 39

Perspective 50 Plus: employment pacts for older workers in the regions, Germany 43

Daily physical education as part of the Comprehensive Health Promotion initiative in schools, Hungary 47

Habitat-Microareas Programme in Trieste, Italy 51

PRISMA-7: detecting and mapping frailty among older people in Friuli Venezia Giulia, Italy 55

SELFIEmployment: supporting young people to become entrepreneurs or self-employed 59

Parental leave policies in Norway: the father's quota 63

The Healthy Generation Project in the Republic of Moldova 67

Baby-friendly Hospital Initiative in the Russian Federation 71

This is Me: mental health programme for youth, Slovenia 75

Promoting health for all through health promotion centres in Slovenia 79

The B-Mincome project: providing low-income families in Barcelona, Spain with financial support and social benefits 83

Disability and rehabilitation in Tajikistan: development of a multisectoral national programme to leave no one behind 87

Achieving sustainable food and nutrition security in rural areas in Tajikistan 91

National Youth Strategy 2016–2025, North Macedonia 95

Strengthening social cohesion between refugees and migrants and the host community in Turkey 99

Arbed and Nest schemes as part of the Welsh Government's Warm Homes Programme 103

The Wales We Want: empowering citizens to own and drive equity policy solutions 107

Cross-Party Group on Health Inequalities, Scotland (United Kingdom) 111

Modelling the impact of minimum price for alcohol in Scotland (United Kingdom) 115

Co-producing policy and research with older people in Manchester, England (United Kingdom) 119

TOY for Inclusion: toys to share, play to care 123

ClairCity: citizen-led air pollution reduction in cities 127

Acknowledgements

This collection of case studies is part of the WHO European Health Equity Status Report Initiative (HESRi). The HESRi is being coordinated by Chris Brown, Head of the WHO European Office for Investment for Health and Development, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe.

The document was prepared by WHO consultants Maria Luisa Buzelli and Tammy Boyce, WHO European Office for Investment for Health and Development (Venice Office).

The Collation benefited from contribution provided by:

Mazen Aboulhosn, Emma Anakhasyan, Colin Angus, Armine Arushanyan, Rasmus Baagland, Viorel Babii, Mustafa Bahadır Sucaklı, Merkur Beqiri, Eivind Berg Weibust, Andrea Bertola, Antonella Biasiotto, Ana Carina Bigot, Bianca Bortot, Corra Boushel, Berit Brandth, Matthias Braubach, Joao Breda, Tine Buffel, Tatjana Buzeti, Jaime Calderon, Pilar Campos Estéban, Angela Capcelea, Steven Chamberlain, Stephanie Chan, Konstance Cimure, Anna Coates, Giulia Cortellesi, Paloma Cuchi, Isabella Danel, Chantal Demilecamps, Aleksandra Dicevska, Cetin Dogan Dikmen, Claudia Ehrenfreund, Marthe Everard, Tamás Evetovits, Tamanna Ferdous, Alison Ferguson, Pietro Orazio Ferlito, Kira Fortune, Mojca Gabrijelcic, Hagverdiyev Gahraman, Pol Gerits, Elena Golubeva, Verena Gregorich-Schega, Hayk Grigoryan, Louise Haag, Triin Habicht, Tatul Hakobyan, Fatos Hande Harmanci, Enda Hayes, Manfred Huber, Charlotte Hvid Olavsgaard, Camilla Ihlebæk, Hana Janata, Dorota Jarosinska, Andreia Jorge Silva, Antoniette Kai-Rak, Daniela Kallayova, Olavi Kangas, Akfer Karaoğlan Kahiloğulları, Selma Kazic, Selami Kılıç, Elena Kjosevska, Kristina Köhler, Taru Koivisto, Ledia Lazeri, Ksenija Lekic, Galina Lesco, Susanne Linden, Joana Madureira Lima, Kat Main, Altın Malaj, Drazenka Malicbegovic, Olga Manukhina, Sari Massiotta, Srdan Matic, Karin Maurer, Simona Melki, Satish Mishra, Lutz Naudet, Marie Nejedlá, Lazar Nikolic, Aasa Nihlén, Victor Stefan Olsavszky, Özlem Onar, Vesna-Kerstin Petrič, Igor Pokanevych, Maria Grazia Pompa, Rade Pribakovic, Marge Reinap, Gill Richardson, Belinda Robson, Urelija Rodin, Kim Rok Ho, Aiga Rurane, Katarzyna Rutkowska, Irina Ryumina, Oliver Schmoll, Serap Şener, Santino Severoni, Nicky Shipton, Natalia Silitrari, Ana Sinkovec, Liv Solveig Korsvik, Annamària Somhegyi, Elena Spasenovska, Vesna Stefancic, Claire Stevens, Kanae Tada, Krisztina Tálas, Jihane Tawilah, Sarah Thomson, Federico Todeschini, Lluis Torrens Mèlich Pavel Ursu, Ingrid Van Hattem-Zuiderwijk, Melita Vujnovic, Elisabeth Waagensen, Martin Weber, Natalie Weerawardane, Sara Wood, Louise Woodfine, Isabelle Yordi, Egor Zaitsev, Gianna Zamaro, Francesco Zambon.

Introduction

The WHO Europe Health Equity Status Report Initiative

Health inequity is one of the main challenges of our time. WHO's European Health Equity Status Report of 2019 reveals how exposure to **five main risks** are holding many children, young people, men and women back from good health and from living a safe and decent life:

1. an absence of free or affordable health services of decent quality;
2. financial insecurity – not being able to make ends meet;
3. poor-quality housing and underdeveloped and unsafe neighborhoods;
4. an inadequate sense of belonging, safety and trust in others; and
5. a lack of employment and job security, poor terms and conditions at work, and higher levels of social exclusion.

The principles of leaving no one behind and creating conditions for all people to flourish in health and in life are essential to implementing the goals of WHO and United Nations agencies, as well as their Members States and partners, and underpin the 2030 Sustainable Development Agenda ***(1)***, WHO's Thirteenth General Programme of Work ***(2)*** and the strategic objectives of the WHO Regional Office for Europe's Health 2020 policy framework ***(3)***. Countries have taken many actions and implemented many policies at local, county, subnational and national levels, but progress in reducing health inequities has been slow.

The WHO European Health Equity Status Report is part of a wider initiative that includes a suite of tools, practical examples and concrete approaches, which, if adopted across the WHO European Region, could create the conditions for all Europeans to be able to live healthy, prosperous lives and with reduced health gaps in the lifetime of a single parliament (five years).

One of the WHO Europe Health Equity Status Report Initiative (HESRi) tools is a series of 32 case studies that illustrate the progress made by countries in the Region in implementing policies and approaches that are evidence informed, have a population effect and improve the health and wellbeing of those being left behind.

The HESRi case series

The case studies include success stories, promising practices and lessons learned from the local, national and European levels that show how countries have:

1. overcome the challenges related to disinvestment in policies and approaches that impact on health equity, and
2. maximized new opportunities for advancing objectives to increase equity in health.

The case studies provide examples of the specific application of intersectoral policy actions and leading equity processes across government and with wider civil society, that are reducing exposures to and the consequences of five key risks which lead to inequities in health. The risks are aligned with the HESRi Analytical Framework (due to be published in September 2019) and the essential conditions needed to be able to live a healthy live in Europe in the 21st century. The cases emphasize the importance of using a combination of policies and services, of the health sector and health sector-led initiatives, and of involving local people, the social economy and wider society.

The cases are structured using the following headings: Description of the intervention; How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life; Relevant HESRi indicators; Links to the HESRi evidence informed policy action areas; and Links to HESRi Drivers.

This publication is intended to stimulate and support action in Member States of the WHO European Region, and to support dialogue for action on health equity with ministries of health and with stakeholders representing the whole of government and the whole of society.

References

1. Transforming our world: the 2030 agenda for sustainable development. Resolution adopted by the General Assembly on 25 September 2015. New York: United Nations; 2015: paragraph 4 (A/RES/70/1; http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E, accessed 24 August 2019).
2. Draft thirteenth general programme of work, 2019–2023. Report by the Director-General. In: Seventy-first World Health Assembly. Geneva: World Health Organization; 2018 (http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1, accessed 24 August 2019).
3. Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf?ua=1, accessed 24 August 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Health Services

Health & Living Conditions

Health & Social and Human Capital

Development of an action plan on the provision of equitable access to water supply and sanitation in Armenia

Description of the intervention

Access to accessible, affordable and safe drinking-water and sanitation services is an essential human right and crucial to human health and well-being. Safe water, sanitation and hygiene (WASH) services prevents illnesses such as cholera and diarrhoea, which still cause 14 diarrhoeal deaths per day in the WHO European Region.[1] Equitable access to safe WASH services for all is critical to ensure good quality health-care facilities, healthy school environments and good quality living conditions. Significant inequities in access to WASH services persist between urban and rural dwellers, wealthy and poor people, and disadvantaged groups and the general population in parts of the Region.

In Armenia provision of an adequate drinking-water supply remains one of the biggest problems in more than 550 rural communities. These services are not usually supplied by organized water service providers. Rural educational facilities frequently rely on infrastructures that are not operational. Despite recent improvements, the gap between urban and rural populations regarding access to safely managed sanitation services was 48% in 2015.[2] To tackle this issue Armenia carried out a self-assessment exercise on equitable access to water and sanitation in 2015–2016 by applying the Equitable Access Score-card, an analytical tool developed under the framework of the Protocol on Water and Health[3] to assist countries in the provision of equitable access.

The self-assessment highlighted key challenges to ensuring equitable access to WASH services, including geographical disparities and affordability issues. Based on the results, Armenia developed Action Plan 2018–2020 on the Provision of Equitable Access to Water Supply and Sanitation in the Republic of Armenia[4] under the joint leadership of the Ministry of Energy Infrastructures and Natural Resources and the nongovernmental organization Armenian Women for Health and Healthy Environment.[5] Several stakeholders participated in the development and implementation of the Action Plan, including the Ministry of Health, Ministry of Labour and Social Affairs, Ministry of Education and Science, Ministry of Territorial Administration and Development, State Committee on Urban Development, the private sector, nongovernmental organizations, civil society organizations and independent experts.

The Action Plan aims to ensure equitable access to safe drinking-water and sanitation for rural communities and for marginalized and vulnerable groups that are not served by organized water service providers. It also aims to ensure access in rural schools and public facilities. Thirteen activities were implemented as part of the initiative, including:

- assessing financial and logistic resources needed to ensure **equitable access** to water and sanitation;
- collecting systematic information about the current situation in those communities not served by an organized water supply and sanitation service provider for the purpose of including them in ongoing projects or developing a **new investment** programme for them; and
- **strengthening** communication and collaboration among different stakeholders to define their roles and responsibilities and increase accountability to ensure equitable access to water and sanitation.

[1] Water and sanitation are still a luxury for millions of Europeans. In: Water and sanitation [website]. Copenhagen: WHO Regional Office for Europe; 2019 (http://www.euro.who.int/en/health-topics/environment-and-health/water-and-sanitation/water-and-sanitation, accessed 20 May 2019).

[2] SDG implementation voluntary national review (VNR) Armenia. Transformation towards sustainable and resilient societies. Yerevan: Republic of Armenia; 2018 (Report for the UN High-level Political Forum on Sustainable Development; (https://sustainabledevelopment.un.org/content/documents/20315Armenia_SDG_VNR_report.pdf, accessed 20 May 2019).

[3] United Nations Economic Commission for Europe, WHO Regional Office for Europe. Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes. Geneva: United Nations Economic Commission for Europe; 1999 (http://www.unece.org/fileadmin/DAM/env/documents/2000/wat/mp.wat.2000.1.e.pdf, accessed 20 May 2019).

[4] Action plan 2018–2020 on the provision of equitable access to water supply and sanitation in the Republic of Armenia. Yerevan: Government of Armenia; 2017 (http://awhhe.am/action-plan-2018-2020-on-the-provision-of-equitable-access-to-water-supply-and-sanitation-in-the-republic-of-armenia/, accessed 20 May 2019).

[5] Armenian Women for Health and Healthy Environment [website]. Yerevan: Armenian Women for Health and Healthy Environment; 2019 (http://awhhe.am/, accessed 20 May 2019).

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The Action Plan reduces the geographical disparities in equitable access to drinking-water and sanitation, with a particular emphasis on closing the urban–rural equity gap.
2. It aims to ensure equitable access to a safe water supply and sanitation for vulnerable and isolated groups.
3. It has also **strengthened** the country's capacity to **increase** transparency and accountability and to develop joint objectives through interministerial collaboration, data collection, **creating** a database and assessing the impact of tariffs on those groups.

Relevant HESRi[6] indicators

- Basic drinking-water services
- Basic sanitation services
- Severe housing deprivation rate
- Self-perceived quality in health care

Links to HESRi policy action areas

Health services

- The lack of adequate WASH services in health-care facilities compromises health services quality and patient and staff safety and may exacerbate the spread of antimicrobial-resistant infections.[7]
- The WHO-recommended water safety plan[8] identifies and mitigates the risks to drinking-water quality and ensures a continuous supply of safe water.

Living conditions

- Safely managed sanitation services ensure healthy and resilient communities, prevents infections and reduces susceptibility among children to malnutrition and other childhood illnesses. The WHO-recommended sanitation safety plan[9] helps to systematically manage sanitation from the user interface to the reuse or disposal of human waste.
- Access to safe drinking-water that is free from contamination prevents waterborne diseases and ensures appropriate personal, household and food hygiene behaviours.

Social and human capital

- Good WASH services in schools are essential to ensure a safe learning environment that enables children to reach their full mental and physical potential.
- Ensuring safe drinking-water, clean and accessible toilets and the provision of handwashing and menstrual hygiene management in schools reduces absenteeism, particularly among girls, and contributes to good learning outcomes.

[6] The WHO European Health Equity Status Report Initiative.
[7] World Health Organization, United Nations Children's Fund. WASH in health care facilities. Global baseline report 2019. Geneva/New York: World Health Organization/United Nations Children's Fund; 2019 (https://apps.who.int/iris/bitstream/handle/10665/311620/9789241515504-eng.pdf?ua=1, accessed 20 May 2019).
[8] A guide to equitable water safety planning: ensuring no one is left behind. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/bitstream/handle/10665/311148/9789241515313-eng.pdf?ua=1, accessed 20 May 2019).
[9] Sanitation safety planning: manual for safe use and disposal of wastewater, greywater and excreta. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/bitstream/handle/10665/171753/9789241549240_eng.pdf?sequence=1&isAllowed=y, accessed 20 May 2019).

Links to HESRi Drivers

- By improving access to WASH services for marginalized groups and those living in rural areas, the Action Plan meets basic human needs, increases community **resilience** and **empowers** people.
- Improving access to WASH services particularly improves conditions for women.
- Increasing **investments** in WASH services improves the participation of all in education, employment and social activities.
- The Action Plan requires integration and collaboration across sectors and programmes at all levels to expand **engagement** beyond the health sector. Multisectoral partnerships increase the effectiveness of the response, as well as policy coherence, which is further strengthened by the SDGs Agenda[10] and the WHO WASH strategy for 2018–2025.[11]

Further information

Tonoyan V. Protocol on water and health – improving health in Armenia through target setting to ensure sustainable water management, access to safe water and adequate sanitation. Geneva/Helsinki: United Nations Economic Commission for Europe/Ministry of Foreign Affairs of Finland; 2014 (https://www.oecd.org/env/outreach/AM_Water%20and%20Health.pdf, accessed 20 May 2019).

United Nations Economic Commission for Europe, WHO Regional Office for Europe. The equitable access score-card: supporting policy processes to achieve the human right to water and sanitation. Geneva: United Nations Economic Commission for Europe; 2013 (https://www.waterlex.org/beta/wp-content/uploads/2018/10/1324456_ECE_MP_WP_8_Web_Interactif_ENG.pdf, accessed 17 May 2019).

van Maanen P, Shinee E, Grossi V, Vargha M, Gabradze, N, Schmoll O. Prioritizing pupils' education, health and well-being. Water, sanitation and hygiene in schools in the pan-European Region. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0007/321838/Prioritizing-pupils-education-health-well-being-en.pdf?ua=1, accessed 20 May 2019).

[10] Transforming our world: the 2030 Agenda for Sustainable Development. New York: United Nations; 2015 (A/RES/70/1; https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf, accessed 20 May 2019).

[11] WHO water, sanitation and hygiene strategy 2018–2025. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/274273/WHO-CED-PHE-WSH-18.03-eng.pdf?ua=1, accessed 20 May 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Living Conditions

Health & Social and Human Capital

Achieving gender equity by sharing experiences: the Gender Equality Map in Melbourne, Australia

Description of the intervention

Gender and other factors (e.g. ethnicity) can influence the way that individuals experience places. These factors can prevent people from enjoying open and public spaces, resulting in lower levels of physical activity and reduced levels of social participation and inclusion in the public sphere. The Australia Institute's report, *Everyday sexism*,[1] suggests that 87% of Australian women have experienced at least one form of verbal or physical street harassment, such as honking, wolf whistling, excessive staring, sexist comments or vulgar gestures.

Safe and strong: a Victorian gender equality strategy was launched in 2016 in Melbourne (Victoria), Australia, to change the attitudes and behaviours required for Sustainable Development Goal 5: achieve gender equality and empower all women and girls.[2] The Gender Equality Strategy identifies early **actions** whereby the Victorian Government and the community can work together in the following key settings: education and training; work and economic security; leadership and participation; health, safety and well-being; sport and recreation; media arts and culture.

To **engage** citizens and to make inequity visible, the Victorian Government funded CrowdSpot and the Monash University XYX Lab to develop the Gender Equality Map. Community members from the local government areas of Darebin and Melton in Melbourne were asked to use the web tool to map their experiences of gender inequity related to community services, public transport, sport facilities and so on.

Users were asked to identify:

- "place spots", such as public transport and infrastructures, which need to be improved; or
- "story spots", by sharing their personal experience or something they have witnessed, such as feelings of being unsafe or a lack of safe and open spaces in the neighbourhood.

The Map allows the community to **influence** the conversation about gender equality as part of the work under the Strategy. Specifically, this tool gives all community members, especially women, girls and less-represented groups, the chance to:

- share opinions and experiences
- identify real issues
- contribute to the design of public spaces.

The Map is collecting data that will be analysed to give better insights and will be used by the Victorian Government to **drive** and **accelerate actions**, increase awareness and **mainstream** gender equity and empowerment.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The Gender Equality Map uses crowd mapping technology to generate geolocative data that will identify hotspots and drive **actions**.
2. The collected information will **inform** future policy development and service delivery to enhance gender equity and tackle sociocultural exclusion to build a more equitable and inclusive society.
3. Engaging the local community makes collecting data on gender and inequity easier and contributes to tackling real issues.

[1] Johnson M, Bennett E. Everyday sexism: Australian women's experiences of street harassment. Canberra: The Australia Institute; 2015 (http://www.tai.org.au/sites/defualt/files/Everyday_sexism_TAIMarch2015_0.pdf, accessed 8 April 2019).
[2] Safe and strong: a Victorian gender equality strategy. Melbourne: Government of Victoria; 2016 (https://www.vic.gov.au/safe-and-strong-victorian-gender-equality#download-the-pdf, accessed 5 April 2019).

Relevant HESRi[3] indicators

- Public spending on housing and community amenities
- Access to public transport
- Feeling unsafe walking alone after dark
- Access to green space
- Perceived ability to influence politics

Links to HESRi policy action areas

Living conditions

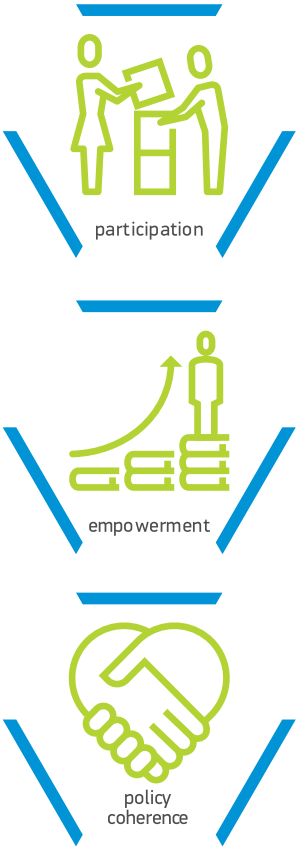
- In those environments with the least resources, there is an increased chance of many girls and young women believing that public places are unsafe for them, particularly after dark, and of being too afraid to use them.[4]
- Spaces with lights, security personnel, emergency services and access to public transport make public spaces more accessible to women, who have a much more varied pattern of movement (e.g. from home, child care, work and shops) compared with men.

Social and human capital

- When the design of community facilities does not promote gender equity, this can affect the community participation of women, men and groups with diverse gender identities. For example, a lack of female or multi-use changing facilities in sports facilities can affect women's participation in organized sport, while a lack of baby changing equipment in mixed-gender toilets can reduce the capacity of men to care for their children.
- Designing services that meet the needs of all individuals promotes inclusion and equity.

Links to HESRi Drivers

- The Gender Equality Map lays the foundation for a more equitable and participatory society by giving everyone the chance to take part in decisions regarding public resource allocation, which will be based on the mapped experiences.
- Local communities take an **active role** in informing equality policies and strategies by identifying risks and sharing personal experiences. This contributes to the generation of collective knowledge.
- The Map empowers those who are usually not involved in public space design. In particular, the Map results in a more equal contribution by both genders to urban policy, which has traditionally been informed by male voices.
- This strategy aligns with the Victorian Government's Gender Equality Strategy and is supported by CrowdSpot, the Monash University XYX Lab, local government and community participants. Every actor has a role to play in developing the Map and collecting data; identifying risks and sharing personal experiences; and translating the findings into actions.



[3] The WHO European Health Equity Status Report Initiative.
[4] Safe public spaces for women and girls. New York: UN Women; 2010, 30 October (http://www.endvawnow.org/en/articles/251-safe-public-spaces-for-women-and-girls.html, accessed 5 April 2019).

Further information

Kneeshaw S. Gender sensitive public space? Placemaking and spatial justice through the perspective of gender. Paris URBACT Programme, European Commission; 2018 (http://urbact.eu/gender-sensitive-public-space-placemaking-and-spatial-justice-through-perspective-gender, accessed 5 April 2019).

Kalms N. Melbourne is mapping gender equality. How and why? Cologny, Switzerland: World Economic Forum, 2018 (https://www.weforum.org/agenda/2018/10/crowd-mapping-gender-equality-a-powerful-tool-for-shaping-a-better-city-launches-in-melbourne/, accessed 5 April 2019).

Francés F, La Parra D, Martínez Román MA, Ortiz-Barreda G, Briones-Vozmediano E. Toolkit on social participation. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0003/307452/Toolkit-social-partecipation.pdf?ua=1, accessed 5 April 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Gender budgeting in Austria: systematically improving equity between women and men

Description of the intervention

Gender gaps persist in employment, education and public life opportunities. Women still earn less than men, dedicate more time to childcare and housework, and have lower participation rates in the labour market. Over many years these disparities have become embedded in public policies and resource allocation, and have impacted the labour market, the education sector and the level of health and well-being of the population. In general, limited education choices based on gender stereotypes affects women's opportunities later in life[1] leading to lower incomes, lower financial security and higher unmet needs for health care for women than for men.

To tackle gender inequity, several countries in Europe have introduced gender budgeting, with the aim of assessing and restructuring public budgets to ensure that women's priorities and needs are considered on an equal basis to those of men. Gender budgeting means first analysing budgets and then restructuring revenues and expenditures in the budgetary process with the aim to **promote gender-responsive policies** and strengthen gender equality in decision-making about public resource allocation, distribution and impacts.[2]

Austria was one of the first countries to implement gender budgeting by including it in the Austrian Federal Constitution in 2009. This reform process resulted in the integration of gender as a mandatory principle in the control and analysis of federal, State and community budgets. The main methodological tool used in gender budgeting in Austria is the identification of gender equality objectives in every budget. The process involves the following steps:

- each ministry and supreme State body define a maximum of five outcome objectives for the annual budget;
- at least one of the outcomes per budget has to address gender equality;
- each ministry and supreme State body define concrete measures and indicators to support the gender outcomes and outputs;
- the National Council receives an annual report on the established outcomes that contains a dedicated chapter on progress made towards equality between women and men; and
- the Court of Audit assesses whether these outcomes and objectives are met.

As a result of this structure, every federal ministry and institution is obliged to define a gender equity objective, which provides an opportunity to strengthen the policy coherence among relevant stakeholders. For instance, the gender equality objective for the area of health is committed to reducing health differences between women and men. Integrating gender budgeting across health policies and programmes enables more efficient financing of the health priorities for both men and women and promotes gender equality.[3]

The gender objectives focus on important policy areas including the gender pay gap; reconciling family life with work and balancing education and professional careers (which differ between women and men because of gender stereotypes); and the representation of women in the boardroom.[4]

The agreed objectives may refer to:

- sociopolitical outcomes (e.g. activities in the ministry's portfolio that contribute to gender equality)
- ministry-specific outcomes (e.g. activities related to a ministry's policy on gender equality).

[1] Women's health and well-being in Europe: beyond the mortality advantage. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0006/318147/EWHR16_interactive2.pdf?ua=1, accessed 27 April 2019).
[2] Gender equality glossary. Strasbourg: Gender Equality Commission, Council of Europe; 2015 (https://edoc.coe.int/en/gender-equality/6947-gender-equality-glossary.html, accessed 27 April 2019).
[3] Strategy on the health and well-being of men in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0010/394894/MHR_strategy_Eng_online.pdf?ua=1, accessed 27 April 2019).
[4] Wirkungsziele nach Untergliederungen [Austrian impact monitoring]. Vienna: Federal Ministry of Public Service and Sports; 2019 (https://www.wirkungsmonitoring.gv.at/2018-massnahmen.html, accessed 27 April 2019).

To strengthen collaboration among ministries, the Inter-Ministerial Working Group for Gender Mainstreaming/Gender Budgeting (IMAG GMB) was established with the aim to:

- monitor and implement the processes of putting gender into the mainstream and of gender budgeting
- exchange experience and good practice
- transfer results.

IMAG GMB's work is further supported by interministerial coordination for gender-related performance budgeting, which supports the multisectoral effort that the strategy relies on and aims to strengthen coordination among ministries and supreme State bodies by creating space for discussion and participation.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The federal budget reform **improved actions** towards gender equity. Since 2013, data have been collected in the *Annual Report on Outcome Orientation* to monitor the progress made towards gender equity and inform discussion and political debate.
2. The federal budget reform is an effective way to promote gender equality in Austria by using existing funds in the most equitable way to **achieve** gender equity.
3. To ensure transparency and outcome orientation, an impact-oriented tool is available for every minister and actor involved, which focuses on the results achieved and the areas that need more work. Everybody can use this tool to monitor the work of all participating in the programme.

Relevant HESRi[5] indicators

- Participation in education and training
- Unemployment rate
- Average wages/earnings
- Self-reported unmet needs for health care

Links to HESRi policy action areas

Health services

- Gender budgeting contributes to promoting access to and a higher quality of health services by allocating public resources in a gender-sensitive way.

Income security and social protection

- Owing to gender pay disparities and the fact that more women are employed part-time and have career interruptions compared with men, the average old-age pension is lower for women.
- As a result of having lower pensions, elderly women, particularly those who live alone, are more often at risk of poverty, which increases the risks of poor health, socioeconomic vulnerability and exclusion.

Social and human capital

- Women are underrepresented in politics and decision-making processes. The degree to which people are able to **influence** decision-making impacts their health and well-being and is a significant determinant of health equity.[6]
- Low levels of education have negative consequences for employment and active social participation. Therefore, gender equity in adult literacy leads to improved health equity.

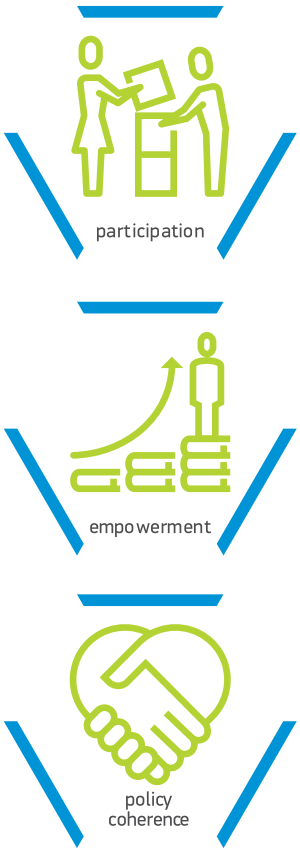
[5] The WHO European Health Equity Status Report Initiative.
[6] Evans GW, Wells NM, Moch A. Housing and mental health: a review of the evidence and a methodological and conceptual critique. J Soc Issues. 2003;59(3):475–500. doi: http://dx.doi.org/10.1111/1540-4560.00074.

Employment and working conditions

- Ensuring equitable participation in secure and decent employment and taking measures to reduce the gender pay gap are powerful approaches to address health and social inequities.[7]

Links to HESRi Drivers

- Tackling resource allocation from a gender perspective can **reduce** gender segregation in educational and employment choices, thereby contributing to the **creation** of a more equal and participatory society.
- Gender budgeting allocates budgetary funds to reduce gender gaps and improve women's opportunities in life. It is therefore a strong tool to **empower** women.
- All ministries participate in the structure responsible for gender budgeting in Austria. To strengthen this structure, policy coherence has been increased by activating many working groups to bring gender into the mainstream as well as IMAG GMB.



Further information

Quinn S. Europe: a survey of gender budgeting efforts. Washington (DC): International Monetary Fund; 2016 (WP/16/155; https://www.imf.org/external/pubs/ft/wp/2016/wp16155.pdf, accessed 27 April 2019).

Downes R, von Trapp L, Nicol S. Gender budgeting in OECD countries. OECD Journal on Budgeting. 2017;16(3). doi: https://doi.org/10.1787/budget-16-5jfq80dq1zbn.

Gender budgeting. Making effective equality between women and men a reality … step by step to a gender-equal budget. Vienna: Federal Minister for Education and Women's Affairs; 2014 (http://www.imag-gmb.at/cms/imag/attachments/1/9/7/CH0619/CMS1465981568160/folder_gender_budgeting_englisch_2016_web.pdf, accessed 27 April 2019).

Gleichstellung von Frauen und Männern in Österreich, Meilensteine, Erfolge und Herausforderungen, 2018. Vienna: Federal Ministry for Women, Families and Youth; 2018 (https://www.frauen-familien-jugend.bka.gv.at/frauen/-sterreichischer-vorsitz-im-rat-der-europ-ischen-union-2018.html, accessed 27 April 2019).

Ensuring gender equity in budgets [blog]. Gender budgeting Vienna: Inter-Ministerial Working Group on Gender Mainstreaming; 2019 (http://blog.imag-gendermainstreaming.at/index.php/en/home-2/, accessed 27 April 2019).

Gender equality: the key to success. Vienna: Federal Chancellery; 2018 (http://www.imag-gmb.at/cms/imag/attachments/5/4/5/CH0618/CMS1536936457191/erfolgsfaktor_gleichstellung_en_be_online-version_final.pdf, accessed 27 April 2019).

Women's health and well-being in Europe: beyond the mortality advantage. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0006/318147/EWHR16_interactive2.pdf?ua=1, accessed 27 April 2019).

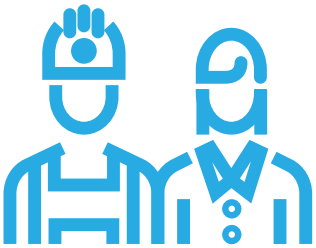
Strategy on the health and well-being of men in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0010/394894/MHR_strategy_Eng_online.pdf?ua=1, accessed 27 April 2019).

Strategy on women's health and well-being in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0003/333912/strategy-womens-health-en.pdf?ua=1, accessed 27 April 2019).

The health and well-being of men in the WHO European Region: better health through a gender approach. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0007/380716/mhr-report-eng.pdf?ua=1, accessed 27 April 2019).

[7] Peppin vaughan R. Gender equality and education in the Sustainable Development Goals. Paris: United Nations Educational, Scientific and Cultural Organization; 2016 (Background paper prepared for the 2016 Global Education Monitoring Report; http://unesdoc.unesco.org/images/0024/002455/245574E.pdf, accessed 27 April 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Employment and Working Conditions

Partnerships for youth employment in the Commonwealth of Independent States, Azerbaijan

Description of the intervention

The global economic crisis has exacerbated the already difficult situation in youth labour markets in eastern Europe and central Asia. The crisis resulted in a dramatic increase in the youth unemployment rate, which has stayed high at 15–17%, three times higher than the adult rate.

Youth unemployment and underemployment increase the chance of unemployment throughout the life-course and of gaining a criminal record.[1] It also leads to skill deterioration and increased risks of social exclusion and of experiencing depression and unhealthy behaviours, such as smoking and drinking.

To tackle this problem, the International Labour Organization and a major Russian enterprise developed the project, *Partnerships for youth employment in the Commonwealth of Independent States*. It aims to deliver results through local partnerships and strategic alliances at subregional level within a network of ten countries: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, Turkmenistan and Uzbekistan. The aim is to share best practices and replicate effective models across the national contexts through the network. Owing to the success of the first phase of the project (2013–2018), a second phase (2018–2022) is now under way.

During the first phase, all countries focused on:

- developing effective youth employment policies and strategies
- **implementing** action plans and programmes for the creation of more and better jobs
- **creating** partnerships at local level to implement the project
- sharing knowledge and experiences with other countries to develop joint approaches.

In Azerbaijan, active labour market programmes have been piloted to support the country's employment strategy. At national level, the project relied on extensive consultations and strategic partnerships among national institutions, social partners (e.g. trade unions, employers' organizations) and the private sector. At regional level, employment policies (including active labour market programmes) in Azerbaijan have been included in the dialogue of the network to incentivize mutual learning and capacity-building. Several actors in each country have taken part in these exchanges, including high-level officials and technical experts representing the ministries of labour, public employment services, and workers' and employers' organizations.

During the first phase of the project, five network meetings took place, in which different countries reviewed another country's policies through several steps.

1. The country under review produced a range of data and documents to support the assessment.
2. The reviewer country analysed the data and prepared documents, conducted site visits to the country under review and then produced a review report, which was reviewed and validated by the network.
3. Recommendations on policy reform and improvements were made to inform the next measures of the country under review.
4. The International Labour Organization prepared a synthesis report, including an outline of the effective practices found in each country.

The network has led to countries (i) **strengthening** their capacity to design, implement and evaluate youth employment policies and programmes and (ii) **increasing** decent work opportunities for young people.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The regional component has allowed countries to share knowledge, tackle common issues related to youth unemployment and develop common solutions.

[1] Gould ED, Hijzen A. Growing apart, losing trust? The impact of inequality on social capital. Washington (DC): International Monetary Fund; 2016 (IMF Working Paper WP/16/176; https://www.imf.org/external/pubs/ft/wp/2016/wp16176.pdf, accessed 25 March 2019).

2. Reviewing each other's policies allowed countries to **cooperate**, improve their strategies and share good practices (e.g. in 2015 the Russian Federation and Kazakhstan reviewed the youth employment policies of Azerbaijan).
3. In Azerbaijan, the project supported the Government's effort to diversify the economy and create new decent jobs, especially for young people.
4. In Azerbaijan the project has directly contributed to the creation of a new Commission on Labour, Economic and Social Affairs and to the adoption of a new National Employment Strategy (2017–2030).

Relevant HESRi[2] indicators

- Unemployment rate
- Labour force participation rate
- Public expenditure on labour market policies
- Labour market insecurity
- Temporary employees
- In-work poverty

Links to HESRi policy action areas

Employment and working conditions

- Young people, who are usually overrepresented in the informal, low-quality job sector, are less likely to have access to the health and social benefits of decent work and to enjoy basic rights at work.
- In countries of the Commonwealth of Independent States, young women are often excluded from an extensive list of jobs, which increases their likelihood of having either lower-paying or informal jobs.[3]
- Long-term unemployment and inactivity have a negative impact on health. They potentially limit access to health services and increase the chance of anti-social behaviours and of unhealthy and risky lifestyles, including drug addiction and delinquency.

Links to HESRi Drivers

- The project has increased the participation of employers' and workers' organizations in the policy debate on youth unemployment. It promotes their involvement in the design, implementation, monitoring and evaluation of labour market policies and programmes.
- The project is based on collaboration between several actors and countries that promotes multisectoral action. It also aligns with the United Nations global initiative, Decent Jobs for Youth,[4] which further strengthens the policy coherence of the project.
- By supporting this project, the Ministry of Labour and Social Protection of the Population **enhances** policy coherence at local level, leading to substantial health improvements. By implementing actions that support youth employment, the project contributes to better health for all.

[2] The WHO European Health Equity Status Report Initiative.
[3] Baskakova M, Soboleva I, Kubishin E. Gender and youth employment in the Commonwealth of Independent States: trends and key challenges. Moscow: The Decent Work Technical Support Team and The ILO Office for Eastern Europe and Central Asia, International Labour Organization; 2017 (https://www.ilo.org/wcmsp5/groups/public/---europe/---ro-geneva/---sro-moscow/documents/publication/wcms_629704.pdf, accessed 25 March 2019).
[4] Impact. In: Decent Jobs for Youth [website]. New York: United Nations; 2017 (https://www.decentjobsforyouth.org/#impact, accessed 29 March 2019).

Further information

Sinelina I, Powers T. Partnerships for youth employment in the CIS: final evaluation. Moscow: International Labour Organization; 2017 (https://www.ilo.org/wcmsp5/groups/public/–-europe/–-ro-geneva/–-sro-moscow/documents/genericdocument/wcms_620038.pdf, accessed 25 March 2019).

ILO Decent Work Technical Support Team, Country Office for eastern Europe and central Asia. Toolkit for conducting voluntary peer reviews on youth employment policies. Moscow: International Labour Organization; 2017 (https://www.ilo.org/global/topics/youth-employment/projects/cis-partnership/WCMS_590095/lang--en/index.htm, accessed 25 March 2019).

ILO Decent Work Technical Support Team, Country Office for eastern Europe and central Asia. Towards policies tackling the current youth employment challenges in eastern Europe and central Asia. Moscow: International Labour Organization; 2017 (http://www.ilo.org/moscow/information-resources/publications/WCMS_575550/lang--en/index.htm, accessed 25 March 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Income Security and Social Protection

Health & Social and Human Capital

Enhancing social protection and inclusion for children in Bosnia and Herzegovina

Description of the intervention

Children's experiences of poverty and vulnerability differ from those of adults and may have a huge impact on physiological and psychosocial health and well-being outcomes throughout the life-course.[1] Child-sensitive social protection systems have a positive impact on chronic poverty and social exclusion and contribute to building more cohesive and inclusive societies.[2]

Bosnia and Herzegovina has fragmented social protection systems and poor social services. To tackle this issue, the country's authorities from different levels, including ministries and civil society organizations, worked together with the United Nations Children's Fund to develop the SPIS (social protection and inclusion services) model, a multidisciplinary mechanism to improve social protection and inclusion systems for children at risk of poverty, social exclusion and family separation and those with no parental care.

The project was developed and implemented from 2008 to 2015 with the aim of empowering local institutions and organizations to formulate individual and collective referral plans for children living in municipalities with the lowest social protection coverage.

At national level, several actors participated in the SPIS model, including the Ministry of Health and Social Welfare, the Ministry of Civil Affairs, the Ministry of Human Rights and Refugees and the Federal Ministry of Labour and Social Policy.

Many local partners worked together to develop individual and collective plans. To facilitate collaboration, permanent local multisectoral coordination platforms were established with the participation of municipal departments for social affairs, centres for social work, schools, health centres, youth councils and representatives from civil society organizations.

To develop individual plans, local stakeholders collaborated to:

- identify child's needs through individual and community approaches;
- draft the plan based on the identified needs; and
- develop the plan in accordance with the available and appropriate social services (e.g. day care, foster care).

To develop municipal plans, local stakeholders focused on:

- the needs common to most at-risk children
- how to create a local effective response to these common needs
- final approval of the local municipal plan.

The project increased investments in municipalities to improve social protection coverage of children and reduce inequities for children in receiving social protection. By focusing on areas with the least resources, the programme demonstrated how different social sectors can collaborate to address a common objective and increase equity.

The development of individual and municipal plans also contributed to:

1. **reducing** differences in access to social protection between children from high-income and low-income municipalities by **strengthening** governance and the legal framework;
2. **enhancing** existing systems and capacities to deliver high-quality inclusive services at local level;
3. establishing new social services for children, such as day care and foster care; and
4. raising public awareness of social inclusion and children's rights through advocacy and awareness campaigns.

[1] UCL Institute of Health Equity. Review of social determinants and the health divide in the WHO European Region: final report. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0004/251878/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-FINAL-REPORT.pdf, accessed 5 April 2019).

[2] Department for International Development, United Kingdom, HelpAge International, Hope & Homes for Children, Institute of Development Studies, International Labour Organization, Overseas Development Institute, et al. Advancing child-sensitive social protection: joint statement on advancing child-sensitive social protection. New York: United Nations Children's Fund; 2009 (https://www.unicef.org/socialpolicy/files/CSSP_joint_statement_8.20.09.pdf, accessed 5 April 2019).

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. Estimates are that at least 5000 children and their parents have benefited from increased access to inclusive and protective social services and approximately 40 000 children have benefited from improved social inclusion and intercultural education.
2. Based on these positive results, the SPIS model was **scaled up** to 34% of municipalities in Bosnia and Herzegovina.
3. The SPIS model improved social protection for children and contributed to improving the availability and quality of social services to children who had been left out of the system (i.e. left behind).
4. The project enhanced policy dialogue and collaboration between actors and technical exchanges among municipalities.
5. The SPIS model contributed to the approval of a new legislation on social protection that introduced the provision of local multisectoral social protection commissions.
6. The new multisectoral platforms contributed to sharing knowledge among stakeholders and designing new policy solutions.

Relevant HESRi[3] indicators

- Poverty
- Social protection expenditure

Links to HESRi policy action areas

Income security and social protection

- Social protection systems prevent children from being exposed to the effects of long-term poverty, which may impact their social, physical and emotional development.
- Social protection targeting the early years and families reduces inequities in health status.

Social and human capital

- Children from lower socioeconomic backgrounds gain the most from the establishment of new social services, such as day care and foster care services.[4]
- Children who have received support from child-care services are less likely to experience unemployment, be involved in criminal activities or have antisocial behaviour. Therefore, these services are powerful drivers of socioeconomic equity.

[3] The WHO European Health Equity Status Report Initiative.
[4] Rocco L, Suhrcke M. Is social capital good for health? A European perspective. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0005/170078/Is-Social-Capital-good-for-your-health.pdf?ua=1, accessed 5 April 2019).

Links to HESRi Drivers

- The SPIS model **contributed** to the promotion of children's rights by enhancing social protection and inclusion services to children who are being left behind.
- Strengthening governance and the legal framework to enhance social protection coverage in municipalities simplified intersectoral cooperation, ensuring the holistic approach of the intervention.
- The SPIS model **improved** the social participation and inclusion of children from municipalities with the lowest social protection coverage.

Further information

Sandu V. Promising practices in social protection for children. Geneva: Regional Office for Europe and Central Asia, United Nations Children's Fund; 2017 (https://www.unicef.org/eca/media/1051/file, accessed 5 April 2019).

Kacapor-Dzihic Z. Final evaluation. Enhancing social protection and inclusion system for children in Bosnia and Herzegovina. Sarajevo: United Nations Children's Fund in Bosnia and Herzegovina; 2015 (https://www.unicef.org/evaldatabase/files/SPIS_EVALUATION_Report_BnH_2015-001.pdf, accessed 5 April 2019).

Protecting workers' health. In: Fact sheets. Geneva: World Health Organization; 2017, 30 November (http://www.who.int/news-room/fact-sheets/detail/protecting-workers'-health, accessed 5 April 2019).

Yamin A, Lander F. Implementing a circle of accountability: a proposed framework for judiciaries and other actors in enforcing health-related rights. J Human Rights. 2015;14(3):312–31. doi: https://doi.org/10.1080/14754835.2015.1056874.

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Income Security and Social Protection

Health & Living Conditions

Health & Social and Human Capital

Boys and Girls Clubs of Calgary: the Infinity Project

Description of the intervention

Youth homelessness in Canada has been an economic and social issue since the 1980s. Many homeless young adults live on the street for long periods of time. The key drivers of youth homelessness are personal issues (e.g. family breakdown and trauma) and financial instability (owing to lack of employment and limited access to benefits). Through leading to mental health disorders, isolation and exclusion, homelessness increases the health risks for people from lower economic backgrounds, who may already have lower levels of health.

In 2009, the Boys and Girls Clubs of Calgary,[1] Canada launched the Infinity Project, which provides young people aged 16–24 years with several **actions** to tackle homelessness and its negative consequences.

The Project provides young adults with:

- permanent housing in a community of their choice, with the aim minimizing the time of housing instability and time spent on the streets – in this stage of the Project, young people are supported by staff to find affordable housing options, communicate with landlords and access financial support;
- **improved life skills** necessary for adulthood and self-sufficiency – the Project's housing support workers mentor young people in working on their personal goals, identifying opportunities, and developing **action plans** for self-care, emotional and mental health, addictions and relationships; and
- **support** to find jobs, enrol in school, learn meal preparation and home management, and reconnect to a positive natural support network.

Once a young person has paid three months of rent on time and completed three months of employment, they are considered to have achieved a stable income to meet their financial responsibilities and they are ready to "graduate" by starting the transition out of the programme. Owing to the complexity of the barriers they face and their developmental needs, homeless young people are able to stay in the Project for up to two years.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. Since its beginning 10 years ago, the Infinity Project has recorded a 70% successful graduation rate.
2. Since 2009, 83.5% of young people in the Project have gained stable housing.
3. When the young people successfully graduate, they leave the programme because either they have a new place to live – sometimes returning to their family home – or they have found employment and are able to support themselves.
4. Partnerships with the wider youth sector in Calgary have ensured a holistic service delivery model, allowing staff to refer young people to a wide range of services throughout the city.

Relevant HESRi[2] indicators

- Severe housing deprivation rate
- Households receiving housing allowance
- Self-reported social support in young people
- Freedom of choice and control over life
- Vulnerable people covered by social assistance programmes

[1] Boys and Girls Clubs of Calgary [website]. Calgary: BGCC Head Office; 2019 (https://www.boysandgirlsclubsofcalgary.ca/, accessed 26 March 2019).
[2] The WHO European Health Equity Status Report Initiative.

Links to HESRi policy action areas

Income security and social protection

- By failing to meet the eligibility criteria, young adults receive fewer financial benefits than older people, which may result in housing insecurity and financial instability.

Living conditions

- Young adults are more likely to have a lower income owing to unemployment, low-paid jobs, reduced access to benefits and insecure housing.
- Housing is an important determinant of health inequalities: people with lower incomes are more likely to be homeless.[3]
- In all, 30–40% of young people who are homeless experience major depression, bipolar disorder, post-traumatic stress disorder and substance use.[4]

Social and human capital

- Most homeless young people are disconnected from their families and do not have healthy supportive relationships, leading to social isolation and loneliness and the associated poorer health outcomes.

Links to HESRi Drivers

- The Infinity Project gives young people the chance to self-discharge at any time and to make decisions about their housing, employment and education. By increasing their perceived sense of control over their life and their ability to make choices, the Project empowers young people.
- The creation of partnerships with local stakeholders has supported the Project in ensuring a holistic supportive model towards reducing homelessness in young people.
- The Project supports young people in developing essential skills which make them able to **actively** participate in the community by enrolling to education and participating in social activities and in the labour market.

[3] Gibson M, Petticrew M, Bambra C, Sowden AJ, Wright KE, Whitehead M et al. Housing and health inequalities: a synthesis of systematic reviews of interventions aimed at different pathways linking housing and health. Health Place. 2011;17(1):175–84. doi: 10.1016/j.healthplace.2010.09.011.

[4] Kidd S. Mental health and youth homelessness: a critical review. In: Gaetz S, O'Grady B, Buccieri K, Karabanow J, Marsolais A, editors. Youth homelessness in Canada: implications for policy and practice. Toronto: Canadian Homelessness Research Network Press; 2013:217–27 (http://www.homelesshub.ca/sites/default/files/YouthHomelessnessweb.pdf, accessed 25 March 2019).

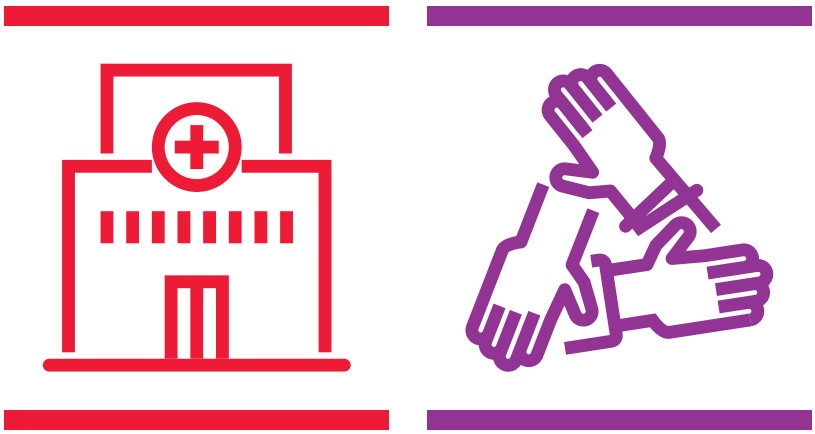
Further information

Boys and girls club of Calgary: the Infinity Project. 2013. Calgary (AB): Homelessness Research Network – The Homeless Hub; 2009 (http://www.homelesshub.ca/sites/default/files/BGCC_0.pdf, accessed 25 March 2019).

Gaetz S. This is housing first for youth: a program model guide. Toronto: Canadian Observatory on Homelessness; 2017 (http://homelesshub.ca/HF4Y, accessed 25 March 2019).

Brown E. Activation of youthworks employment toolkit: summary report. Toronto (ON): Raising the Roof; 2014 (https://www.raisingtheroof.org/wp-content/uploads/2015/10/2014_RtR_Youthworks_SummaryReport_FINAL.pdf, accessed 25 March 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Health Services

Health & Social and Human Capital

Effective health promotion for people at risk of poverty and social exclusion in Czechia

Description of the intervention

People from lower socioeconomic backgrounds have a shorter life expectancy, report worse subjective health and are more likely to have worse lifestyle behaviours (e.g. low physical activity, smoking, unhealthy diet).[1,2] These factors are linked to higher rates of cardiovascular, digestive and respiratory diseases, and are more common among those living in low-income areas.[3] In addition, people from lower socioeconomic backgrounds are at a higher risk of social exclusion and face difficulties in accessing good quality health and social services.[4]

In Czechia about 1.3 million people (12% of the current population) are at risk of poverty and social exclusion.[5] This is strongly related to a low level of education, which has lowered their life expectancy by about 10 years compared with people with a high level of education.[6] To reduce health inequities across the population and provide effective support to those most at risk of poverty and social exclusion, the Ministry of Health and the National Institute of Public Health in Czechia established 14 regional health promotion centres (one for each region) to support the implementation of new health promotion intervention programmes.

Since 2018 the programme has targeted health professionals and the broader community through a range of different activities.

- Health professionals have undertaken an 80-hour training course to act as health promotion mediators. In this role, they provide support in the health promotion centre to people at risk of poverty and social exclusion to meet their health needs, improve health literacy and encourage the adoption of a healthy lifestyle.
- Following the mediator training courses, preventive programmes will be implemented over a two-year period (2020–2022).
- In cooperation with external experts, the programme has established health promotion programmes based on 11 thematic units: hygiene, healthy living, healthy nutrition, examination of basic body and blood parameters, prevention of infectious diseases, addiction prevention, physical activity, mental health, cancer prevention, injury prevention and traffic education, and reproductive health. These themes are addressed through activities such as individual interventions, healthy lifestyle courses, physical activity courses, health days and lectures.

In addition, the health promotion centres also aim to connect key partners at regional level to enhance collaboration and adopt an integrated approach to ill-health prevention and health promotion. Key partners include practitioners for children and adolescents, general practitioners for adults, the national Agency for social inclusion, non-profit-making organizations and relevant stakeholders who are interested in cooperating to improve health-related decisions and to map health-related needs.

The multisectoral collaborative effort and theoretical knowledge of each partner contribute to develop a holistic response to the needs of the target group of each region.

[1] Peppin Vaughan R. Education for people and planet: creating sustainable futures for all. Gender equality and education in the Sustainable Development Goals. Paris: United Nations Educational, Scientific and Cultural Organization; 2016 (ED/GEMR/MRT/2016/P1/7REV; http://unesdoc.unesco.org/images/0024/002455/245574E.pdf, accessed 13 May 2019).
[2] Action plan for the prevention and control of noncommunicable diseases in the WHO European region. Copenhagen: WHO Regional Office for Europe; 2016 (EUR/RC66/11+EUR/RC66/Conf.Doc./7; http://www.euro.who.int/__data/assets/pdf_file/0011/315398/66wd11e_NCDActionPlan_160522.pdf?ua=1, accessed 13 May 2019).
[3] The Tallinn charter: health systems for health and wealth. Copenhagen: WHO Regional Office for Europe; 2008 (http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf?ua=1, accessed 13 May 2019).
[4] Poverty, social exclusion and health systems in the WHO European region. Copenhagen: WHO Regional Office for Europe; 2010 (http://www.euro.who.int/__data/assets/pdf_file/0004/127525/e94499.pdf?ua=1, accessed 13 May 2019).
[5] People at risk of poverty or social exclusion. Luxembourg: Eurostat; 2017 (https://ec.europa.eu/eurostat/statistics-explained/index.php?title=People_at_risk_of_poverty_or_social_exclusion&oldid=278750, accessed 13 May 2019).
[6] Health at a glance 2017: OECD indicators. Paris: OECD Publishing; 2017 (https://www.oecd-ilibrary.org/docserver/health_glance-2017-en.pdf?expires=1557747543&id=id&accname=guest&checksum=B6B077C758CBA5E25E0EAA2C5B3286AF, accessed 13 May 2019).

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

- The first training course for health promotion mediators took place in October and November 2018. It was attended by 78 people.
- Investing in disenfranchised groups reduces health inequities and equalizes the opportunities for all.
- The establishment of health promotion centres in each region enables the rapid identification of the population's needs and a rapid response to these needs through developing suitable community-adapted preventive care programmes.
- Enhancing collaboration with the social sector, non-profit-making organizations and local stakeholders helps to reduce barriers in accessing the health and related social systems for people at risk of poverty and social exclusion.

Relevant HESRi[7] indicators

- Public expenditure on health
- Avoidable hospital admissions
- Self-perceived quality in health care
- Life expectancy at birth
- Poverty
- Having someone to ask for help

Links to HESRi policy action areas

Health services

- Providing low-income areas with health promotion centres makes residents more likely to access these services and reduce their unmet health-care needs.
- Providing health professionals with a training course sustains local health development and improves the response of health services to local needs.

Social and human capital

- Ill-health prevention programmes can increase individuals' health literacy, which positively impacts their quality of life by influencing their health behaviours.[8]
- Health literacy empowers individuals and gives them the ability to have a more active role in decision-making and management regarding their health.

[7] The WHO European Health Equity Status Report Initiative.
[8] Nutbeam D. Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. Health Promot Int. 2000;15(3):259–67. doi: https://doi.org/10.1093/heapro/15.3.259.

Links to HESRi Drivers

- Setting up health promotion centres at local level strengthens a community's resilience and empowers those from lower socioeconomic backgrounds, who are at most risk of poverty and social exclusion.
- The establishment of regional health promotion centres makes individuals more likely to participate in health promotion activities and increases their sense of inclusion.
- The regional centres strengthen a multisectoral approach to health promotion by improving relationships between key partners and regional actors with vital roles in primary prevention and health promotion. This broad collaboration enhances policy coherence for the programme.

Further information

Health 2020: education and health through the life-course. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/__data/assets/pdf_file/0007/324619/Health-2020-Education-and-health-through-the-life-course-en.pdf?ua=1, accessed 13 May 2019).

Engagement and participation for health equity. Copenhagen: WHO Regional Office for Europe; 2017 (http://www.euro.who.int/__data/assets/pdf_file/0005/353066/Engagement-and-Participation-HealthEquity.pdf?ua=1, accessed 13 May 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Income Security and Social Protection

The Danish pension system: preventing elderly people from falling into poverty

Description of the intervention

Although life expectancy is increasing across the WHO European Region, health inequities persist in every country. These inequities are driven by socioeconomic factors and result in differences in healthy life expectancy. As a consequence, many people do not enjoy good health in the final years of life. People from low-income neighbourhoods still experience difficulties in accessing pension plans or have inadequate savings rates. The resultant financial instability may increase the number and severity of unmet health-care needs and worsen the already poor living conditions of older people.

Financially secure retirement systems are critical to improving health outcomes for older populations and enabling older people to live more years in good health.

Denmark has developed a pension scheme to respond to current retirement challenges, with three main pillars:

1. a **state pension** that consists of a residence-based pension comprising (i) a basic pension, (ii) a pension supplement and (iii) additional supplements such as a supplementary pension benefit;
2. **semi-mandatory occupational pensions** (labour market pensions), consisting of privately funded occupational pension schemes based on collective agreements between the employer and employee representatives; and
3. an **individual pension**, consisting of voluntary pension savings.

The state pension is income tested and provides a basic income to all pensioners. ATP, the Danish Labour Market Supplementary Pension[1], is part of the first pillar and covers approximately 90% of Danish pensioners.

For those with a lower income, the government provides other benefits such as housing benefits, heating benefits, health allowance and assistance in special cases. These benefits are means tested and reduce inequities between elderly people with higher pensions and those with minimum pensions.

The occupational pension schemes are fully funded and agreed between social partners through collective agreements. They cover about 90% of the workforce.

The Danish pension system is continually reviewed to ensure that it is equitable and sustainable for future generations. In doing so, the system has linked the official retirement age to life expectancy gains, meaning that although the Danish retirement age is still 65 years, it will rise to 67 years in 2019–2021 and to 68 years in 2030.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The Danish pension system is a robust, adequate and sustainable scheme. Tax-funded old-age pensions for all are combined with savings-based occupational pensions for almost all wage-earners.
2. ATP provides lifelong annuity pensions to most of the Danish population, representing basic security for all.
3. The minimum pension in the Danish system prevents older people from falling into poverty and reduces the income gap among pensioners.
4. The multipillar pension scheme ensures high savings rates and a sustainable system.

Relevant HESRi[2] indicators

- Poverty
- Pension net replacement rate
- Pension coverage
- Pension expenditure per beneficiary

[1] Arbejdsmarkedets Tillægspension.
[2] The WHO European Health Equity Status Report Initiative.

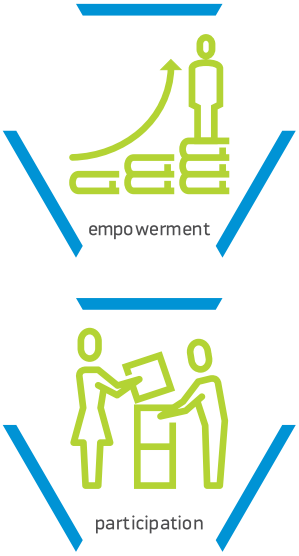
Links to HESRi policy action areas

Income security and social protection

- Financial insecurity increases the risk of poverty, which worsens physical and mental health conditions, and reduces the ability to afford necessities such as food, heating and transportation.
- Pensions are an important means to support functional ability of older people, maintain intrinsic capacity and enable them to perform daily tasks.[3]
- An equitable pension scheme that covers all socioeconomic groups ensures a reliable source of income, increases financial stability and equalizes the opportunities for health.

Links to HESRi Drivers

- Equitable pension schemes can reduce the inequalities accumulated over the life-course, thus improving the well-being of those from lower socioeconomic backgrounds.
- Improving the financial security of older people positively impacts their ability to meet their needs. It also increases their perceived level of self-esteem, ability to make choices and sense of independence.
- An adequate pension gives older people the chance to be independent for longer, thus contributing to healthy ageing, and positively impacts their engagement and participation in the community.[4]



[3] Social protection for older persons: key policy trends and statistics. Geneva: International Labour Organization; 2014 (Social Protection Policy Papers No. 11; http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_310211.pdf, accessed 27 April 2019).

[4] World report on ageing and health. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf?sequence=1, accessed 27 April 2019).

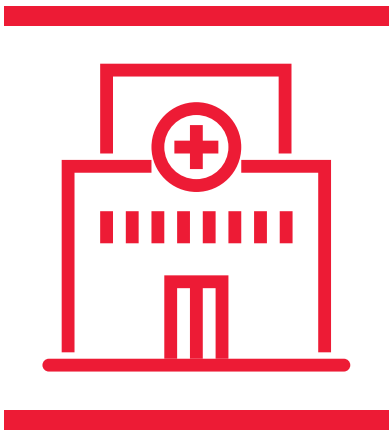
Further information

Case studies in retirement system reform. Geneva: World Economic Forum; 2017 (http://www3.weforum.org/docs/WEF_Retirement_Handbook_2017.pdf, accessed 27 April 2019).

Andersen JG. The Danish pension system. London: Policy Network; 2016 (https://www.dps.aau.dk/digitalAssets/266/266013_goul-andersen-danish-pension-system.short-paper.2016.pdf, accessed 27 April 2019).

Pension at a glance 2017: OECD and G20 indicators. Country profile: Denmark. Paris: OECD Publishing; 2017 (https://www.oecd-ilibrary.org/docserver/pension_glance-2017-en.pdf?expires=1556379188&id=id&accname=guest&checksum=22D1A708EBA6802C878D5E78BA74DC93, accessed 27 April 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Health Services

Reducing co-payments in Estonia through information technology solutions

Description of the intervention

Out-of-pocket payments can create a financial barrier to accessing health services, resulting in unmet need for health care, as well as financial hardship for people using health services.[1] Lack of financial protection in health systems is most likely to affect people with low incomes and frequent users of health services. It may lead to or deepen poverty, undermine health status and widen health and socioeconomic inequalities. Since all health systems involve some form of out-of-pocket payment, financial hardship linked to the use of health services can be a problem for any country.

A recent case study found that the extent of financial hardship in Estonia is quite high compared with many other European Union countries.[2] It is heavily concentrated among poor households and mainly driven by household spending on outpatient prescribed medicines. Outpatient prescription medicines in Estonia are subject to a fixed co-payment of €2.50 per prescription. People also pay a percentage co-payment (between 0% and 50% of the price of the medicine) and any cost difference between a medicine's reference price and actual retail price.

Mechanisms to protect people from co-payments include the additional reimbursement of 50% of all out-of-pocket payments (including both the fixed and percentage co-payments) once a person has spent more than €300 in a single year on prescription medicines, increasing to 90% of any out-of-pocket payments once a person has spent more than €500 in a single year.[2] As many patients were unaware of these additional reimbursements and the stringent application process required strict record-keeping of spending on prescriptions, very few benefited from this protection mechanism.

In 2018 the Estonian Health Insurance Fund amended the system to provide better protection for people facing relatively high out-of-pocket payments for medicines.

- Co-payment protection is now implemented automatically through the pharmacy's information technology system – people no longer have to apply for it and they are no longer reimbursed retrospectively.
- The first threshold for receiving what is now known as additional coverage was lowered from €300 to €100 – after spending €100 out of pocket, a person only has to pay 50% of any further out-of-pocket payment requirements.
- The second threshold for receiving additional was lowered from €500 to €300 – after spending €300 out of pocket, a person only has to pay 10% of any further out-of-pocket payment requirements.

As a result of these measures, the number of people benefiting from the reduced percentage co-payment increased by more than 40-fold (from 3000 in 2017 to 134 000 in 2018), while the number of people spending more than €250 per year on outpatient prescribed medicines fell dramatically (from 24 000 in 2017 to 1000 in 2018).

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. Information technology solutions make applying for health benefits a seamless and effortless process for patients, ensuring that everybody who is eligible benefits. This will lower barriers to accessing outpatient prescribed medicines and reduce financial hardship for those at a high risk of financial hardship and of having unmet needs.
2. Coverage policy design that aims to target people on low incomes and frequent users of medicines and other health services is essential to reduce health inequities.
3. Reducing co-payments helps countries to meet the challenge of leaving no one behind by ensuring that people on low incomes have equal access to the health system.

[1] Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: WHO Regional Office for Europe; 2019 (https://apps.who.int/iris/bitstream/handle/10665/311654/9789289054058-eng.pdf?sequence=1&isAllowed=y, accessed 20 May 2019).

[2] Võrk A, Habicht T. Can people afford to pay for health care? New evidence on financial protection in Estonia. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0004/373576/Can-people-afford-to-pay-for-health-careEstonia-WHO-FP-004.pdf?ua=1, accessed 20 May 2019).

Relevant HESRi[3] indicators

- Out-of-pocket expenses
- Impoverishing out-of-pocket payments
- Catastrophic out-of-pocket payments
- Self-reported unmet need for health care
- Unmet need for family planning services

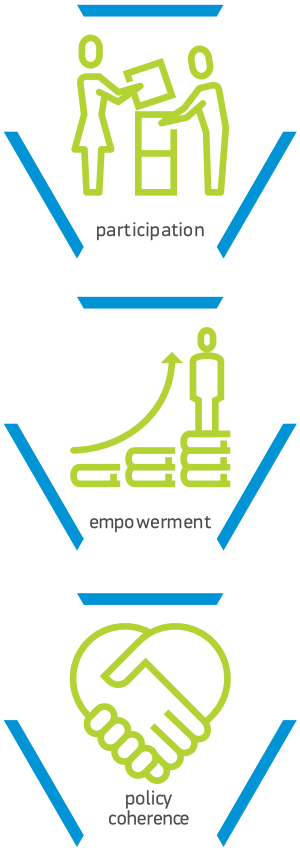
Links to HESRi policy action areas

Health services

- Gaps in coverage not only lead to financial hardship but also create barriers to accessing health services, leading to unmet need for health care.
- Policies that reduce financial barriers to accessing health services have a positive impact on health equity by reducing differences in health and well-being between social groups.[4]
- Universal health coverage has a major equity impact by ensuring that everyone can use appropriate and effective health services without financial hardship, irrespective of their ability to pay, race, religion, sexuality, gender or ethnicity.

Links to HESRi Drivers

- Equity in the use of health services with financial protection enhances the health and well-being of the population. Healthy individuals are more likely to participate in the life of the community and engage in public activities.
- Strong health coverage policies limit the risk of poverty and social exclusion, thereby improving individuals' perception of power and control over destiny.
- This measure is consistent with the Tallinn Charter, which promotes equity, solidarity, financial protection and better health through health system performance monitoring, assessment and improvement.[4]



[3] The WHO European Health Equity Status Report Initiative.
[4] The Tallinn Charter: health systems for health and wealth. Copenhagen: WHO Regional Office for Europe; 2008 (http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf, accessed 20 May 2019).

Further information

Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: WHO Regional Office for Europe; 2019 (https://apps.who.int/iris/bitstream/handle/10665/311654/9789289054058-eng.pdf?sequence=1&isAllowed=y, accessed 20 May 2019).

Financial protection in high-income countries. A comparison of the Czech Republic, Estonia and Latvia. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0004/372811/czechia-estonia-latvia-fp-2018-eng.pdf?ua=1, accessed 20 May 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Income Security and Social Protection

Health & Social and Human Capital

The basic income experiment in Finland

Description of the intervention

People from lower socioeconomic backgrounds are more likely to live in poverty, which increases the risks of vulnerability and exclusion and negatively impacts health and well-being. National poverty rates have decreased in central Asia, the Caucasus and the western Balkans; however, many European countries that use relative poverty (defined as household income below 60% of the national median income)[1] to measure poverty have seen a growing number of people living in relative poverty.

Several income assistance systems have been tested to reduce poverty and inequalities among the population. However, means-tested and conditional basic income assistance systems in mature welfare states have generated poverty traps and had adverse impacts on the health of beneficiaries, with the recipients of in-work or out-of-work benefits being more likely to suffer adverse impacts on health and well-being linked to cumulative poverty.

The main priorities are to find a way to reverse this effect and to ensure that income assistance systems **support** a reduction in health inequities. Providing a universal basic income (UBI) is increasingly being discussed as more effective way to manage social protection systems, which can disincentivize people from working because they lose benefits if they find work (even temporary or part-time work) or keep them trapped in poverty. UBI is also seen as a way to remove the adverse health impacts of benefits systems.

In a UBI system all citizens are paid a cash grant unconditionally, without means testing or work requirements. This approach **generates** security and removes disincentives to work, which are intrinsic to many current benefits systems, and allows citizens to retain their earnings and savings.[2]

The Finnish Government carried out one of the largest UBI experiments over two years (January 2017 to December 2018). The study involved input from Kela (the Social Insurance Institution of Finland) and experts from the University of Turku. According to the Finnish Government, the basic income experiment aimed to:

- find ways to **reshape** the social security system in response to changes in the labour market; and
- explore how to **improve** the system and make it more effective (e.g. by providing incentives for work, reducing bureaucracy, providing welfare benefits).

Under the terms of the experiment, 2000 unemployed individuals aged between 25 and 58 years received a monthly unconditional payment of €560. Individuals in the treatment group were selected randomly from over the whole country. The composition of the treatment and control groups was identical at the beginning of the experiment. This enabled assessment of the impact of the project on the treatment group.

The results included many lessons learned on how to implement future UBI projects. Evaluation of the Finnish UBI system showed that:[3]

- a longer experiment is needed to identify significant effects on behaviour;
- the cash grant should be universal;
- the experiment should focus on testing several measures of well-being (e.g. surveys, face-to-face interviews);
- the experiment should not be influenced by existing features of benefit systems (e.g. housing support); and
- the benefits received by individuals in UBI experiments should not be means tested.

[1] Directorate-General for Employment, Social Affairs and Inclusion. The measurement of extreme poverty in the European Union. Brussels: European Commission; 2011 (https://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=982&furtherNews=yes, accessed 3 May 2019).
[2] Haagh L. The case for universal basic income. Cambridge: Polity Press; 2019.
[3] Kangas O, Honkanen P, Hämäläinen K, Kanerva M, Kanninen O, Laamanen J-P et al. From idea to experiments: final report on Implementation of the options for basic income experiment. Helsinki: Prime Minister's Office of Finland; 2016 (in Finnish; https://tietokayttoon.fi/documents/10616/1034423/63-2016-Ideasta+kokeiluihin+loppuraportti.pdf/1d0b95e2-ac3d-331c-f83e-e2ccd41606de/63-2016-Ideasta+kokeiluihin+loppuraportti.pdf.pdf?version=1.0, accessed 3 May 2019).

The Finnish basic income experiment has been valuable for testing the impact of the UBI programme on health and well-being. The study showed positive results:[4]

- 56% of participants in the treatment group reported a good level of health (versus 46% of those in the control group);
- 68% of participants in the treatment group reported an increase in financial incentives (versus 42% in the control group);
- 57% of those in the treatment group reported a reduction in bureaucratic barriers (versus 37% in the control group).

The experiment also increased recipients' motivation to find full-time employment.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The results of the Finnish basic income experiment support the hypothesis that granting unconditional basic income assistance has positive effects on health and motivation to find employment.
2. Despite concerns that the removal of conditions on income support could have lowered levels of employment, data for the first year (2017) shows that employment levels did not decrease. However, employment levels did not increase in the control group either.
3. These results should encourage multisectoral actions between health sectors and income support systems, which could strengthen the framework of the intervention and policy coherence for the experiment.

Relevant HESRi[5] indicators

- Poverty
- Social protection expenditure
- Vulnerable people covered by social assistance programmes

Links to HESRi policy action areas

Income security and social protection

- Providing those with limited resources with unconditional cash grants has a **health-promoting effect**. It reduces poverty and improves mental health by reducing levels of anxiety and stress.

Social and human capital

- Increasing financial stability and ensuring appropriate and equitably shared opportunities (e.g. for work, education, skills development) across the life-course improves people's level of health and well-being and **breaks** the cycle of poverty.
- UBI improves the financial stability of those with the fewest resources.

[4] Preliminary results of the basic income experiment: self-perceived wellbeing improved, during the first year no effects on employment. Helsinki: Social Insurance Institution; 2019, 8 February (Press release; https://www.kela.fi/web/en/-/preliminary-results-of-the-basic-income-experiment-self-perceived-wellbeing-improved-during-the-first-year-no-effects-on-employment, accessed 3 May 2019).

[5] The WHO European Health Equity Status Report Initiative.

Links to HESRi Drivers

- Alleviating poverty empowers those communities with the least resources and **encourages social capital**, which affects the health of people living in low-income areas.
- The basic income experiment in Finland increased recipients' motivation to find full-time employment. This generated higher levels of engagement and participation in decision-making and **enhanced** people's self-determination and perceived level of control.
- The Finnish Government collaborated with different stakeholders from different fields. This improved the framework of the intervention and the policy coherence for the experiment.

Further information

Kangas O, Kalliomaa-Puha L. Basic income experiment in Finland. Brussels: Directorate-General for Employment, Social Affairs and Inclusion, European Commission; 2016 (ESPN flash report 2016/13).

Experimental study on a universal basic income. Helsinki: Social Insurance Institution; 2019 (https://www.kela.fi/web/en/basic-income-experiment, accessed 3 May 2019).

The basic income experiment 2017–2018 in Finland: preliminary results. Helsinki: Ministry of Social Affairs and Health of Finland; 2019 (http://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161361/Report_The%20Basic%20Income%20Experiment%2020172018%20in%20Finland.pdf?sequence=1&isAllowed=y, accessed 3 May 2019).

Haagh L. Public state ownership within varieties of capitalism: regulatory foundations for welfare and freedom. Int J Public Policy. 2019;15(1/2):153–86. doi: https://doi.org/10.1504/IJPP.2019.099056.

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Income Security and Social Protection

Health & Employment and Working Conditions

Perspective 50 Plus: employment pacts for older workers in the regions, Germany

Description of the intervention

Older people often experience discrimination in the labour market because of ageist stereotypes.[1] By 2080, a third of the European Union population is expected to be over 65 years of age.[2] Despite the increasing average healthy life expectancy, not all older people who want to work have equal access to employment.

Work and employment are crucial for health and well-being. Especially in later life, labour market opportunities lead to a more active lifestyle, higher financial security, higher self-esteem and social inclusion.

Germany has one of the oldest populations in the European Union. To support productive ageing (i.e. engaging older people in any activity that produces goods or services for society), the German Government implemented the Perspective 50 Plus Programme. The Programme was part of Initiative 50 Plus, led by the Federal Ministry of Labour and Social Affairs, and was implemented in three phases from 2005 to 2015. The Programme aimed to reintegrate long-term unemployed people aged 50 years and over into the labour market.

To **facilitate** the participation of older unemployed persons in the labour market, the Programme identified regional solutions through creating regional employment pacts. These pacts increased employment opportunities and established regional networks of regional and local companies (e.g. large, small and medium enterprises), scientific institutions, chambers of commerce, employment agencies and the broader community. This cross-sectoral approach contributed to:

- **increasing awareness** (through publicity campaigns) about the potential benefits of hiring older people;
- reducing stigma and discrimination based on ageist stereotypes to increase the participation of older people in the labour market;
- establishing new measures to **increase** work opportunities for older people (e.g. wage subsidies); and
- **empowering** local stakeholders to meet the needs of the region by reintegrating older people into the labour market.

This new form of regional cooperation involved the establishment of job centres to mediate and facilitate links between employment agencies and job candidates.

Analysis of the success factors of the Programme showed that this strategy would have benefited long-term unemployed people, regardless of age. The experience of Perspective 50 Plus informed current plans, which aim to reduce long-term unemployment among older people and other population groups. Based on the experiences of Perspective 50 Plus, current concepts and projects such as MitArbeit[3] and Networks ABC[4] support long-term unemployed people by providing counselling and job opportunities.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. In the first phase of the Programme, more than 22 000 low- or semi-skilled older people were reintegrated into the labour market. In the second phase, the Programme enabled more than 106 000 older people to return to work. In the third and final phase, the Programme reintegrated around 311 000 older people into employment.

[1] Ageing in the 21st century: a celebration and a challenge. New York/London: United Nations Population Fund/HelpAge International; 2012 (https://www.unfpa.org/sites/default/files/pub-pdf/Ageing%20report.pdf, accessed 27 April 2019).
[2] Population structure and ageing. In: Eurostat statistics explained [website]. Luxembourg: European Commission; 2018 (https://ec.europa.eu/eurostat/statistics-explained/index.php/Population_structure_and_ageing#The_share_of_elderly_people_continues_to_increase, accessed 27 April 2019).
[3] Infografik "MitArbeit" neue Teilhabechancen für Langzeitarbeitslose auf dem allgemeinen und sozialen Arbeitsmarkt schaffen. Berlin: Federal Ministry of Labour and Social Affairs; 2019 (https://www.bmas.de/SharedDocs/Bilder/DE/Infografiken/Arbeitsmarkt/mitarbeit-teilhabechancen-langzeitarbeitslose.html?cms_notFirst=true&cms_docId=711424, accessed 2 May 2019).
[4] Netzwerke für Aktivierung, Beratung und Chancen. Berlin: Federal Ministry of Labour and Social Affairs; 2019 (https://www.sgb2.info/DE/Themen/ABC-Netzwerke/abc-netzwerke.html, accessed 2 May 2019).

2. The Programme is a potential solution to **strengthen** the sustainability of the pension system, which is threatened by an increasing older population, most of whom are not working.
3. Perspective 50 Plus raised awareness on the current demographic challenge and tackled gender stereotypes by reducing the barriers that older people face in returning to work.

Relevant HESRi[5] indicators

- Unemployment rate
- Labour force participation rate
- Labour share of gross domestic product

Links to HESRi policy action areas

Income security and social protection

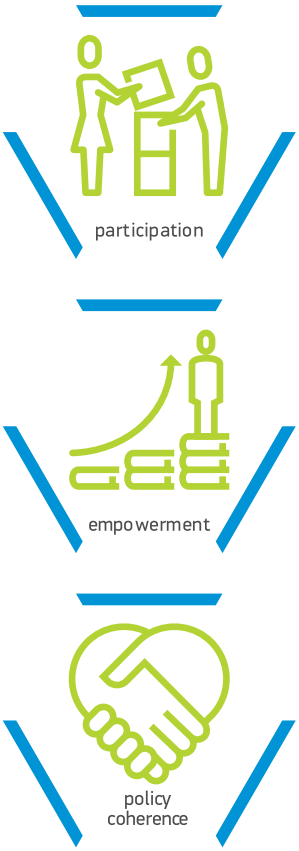
- Redistributive systems (e.g. wage subsidies) address inequities and ensure an adequate standard of living for older people, thereby preventing a negative impact on health.

Employment and working conditions

- Investing in programmes to ensure employment opportunities for all has the power to boost labour productivity and address health and social inequities by providing equitable opportunities for all.
- Exclusion from the labour market significantly affects the physical health, mental health and psychosocial well-being of unemployed people.[6]
- An adequate minimum wage or adequate wage subsidies improve mental health and financial stability, thereby contributing to reductions in mortality.[7]

Links to HESRi Drivers

- Participation in the labour market improves social connections and reduces discrimination. In later life, social networks and the absence of discrimination and stigma are crucial for creating an age-friendly environment.
- Perspective 50 Plus reduces the barriers that prevent older people from entering the labour market, which improves their sense of control and self-esteem.
- Perspective 50 Plus was built on cross-sectoral regional cooperation that **enhanced** policy coherence at local level.



[5] The WHO European Health Equity Status Report Initiative.
[6] Quinlan M. The effects of non-standard forms of employment on worker health and safety. Geneva: International Labour Organization; 2015 (Conditions of Work and Employment Series No. 67; https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_443266.pdf, accessed 27 April 2019).
[7] Peppin Vaughan R. Gender equality and education in the Sustainable Development Goals. Paris: United Nations Educational, Scientific and Cultural Organization; 2016 (Background paper prepared for the 2016 Global Education Monitoring Report; http://unesdoc.unesco.org/images/0024/002455/245574E.pdf, accessed 27 April 2019).

Further information

Germany. “Perspective 50 Plus”: employment pacts for older workers in the regions. Organization for Economic Co-operation and Development; 2006 (http://www.oecd.org/regional/leed/37729545.pdf, accessed 27 April 2019).

Preventing ageing unequally. Paris: OECD Publishing; 2017 (http://www.quotidianosanita.it/allegati/allegato9824468.pdf, accessed 27 April 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Living Conditions

Health & Social and Human Capital

Daily physical education as part of the Comprehensive Health Promotion initiative in schools, Hungary

Description of the intervention

Engaging in regular physical activity has a wide range of positive effects on health and well-being. It prevents hypertension and obesity, noncommunicable diseases (NCDs; such as cardiovascular and musculoskeletal diseases), diabetes and cancer and improves mental health by reducing levels of stress and anxiety. Data show that three out of four adolescents do not currently meet the global recommendations for physical activity (that is, 60 minutes per day of physical activity).[1]

The Act on Healthcare adopted by the Hungarian Government in 2011 set the background for comprehensive health promotion and disease prevention at school.[2] Under the leadership of the Health Department and with the support of the Department of Education, the Comprehensive Health Promotion initiative aims to ensure that all children participate in health-promoting activities focused on physical and mental health and well-being.

The initiative focuses on the following four health-promoting activities.

1. Healthy diet and nutrition. this activity **influences** and **promotes** healthy food choices and nutritional habits. It is supported by the School Garden Programme, an outdoor educational tool implemented in 10 public schools that establishes gardens with the aim of promoting healthy food and agricultural education through mentoring by local farmers.
2. Daily physical education. Every school day, children should participate in a physical education class that includes relaxation exercises, the proper level of cardiovascular strain, dancing, games and posture-correcting exercises. The results are measured yearly through NETFIT, a national measurement tool.
3. New appropriate pedagogic methods. These aim to support teachers in their daily work to promote mental health using cooperative and problem-centred learning and art classes in subjects such as singing and painting.
4. A health literacy programme. With the help of county public health departments, this programme aims to **raise** the level of health literacy among adolescents by addressing health topics in new and interesting ways.

To contribute to the Comprehensive Health Promotion initiative and promote good health among children, the Hungarian Government has implemented several measures since 2010, including:

- building more school gyms and swimming pools;
- improving the accessibility of green spaces to promote physical activity after school; and
- reducing smoking through measures such as banning smoking in some outdoor public spaces, increasing tax on cigarettes and restricting of the number of shops selling tobacco products.

These measures have started to have positive results. For example, the combined effect of the smoking ban and other effective tobacco-control measures was a significant decrease in the proportions of adult daily smokers and of youths (aged 13–15 years) experimenting with tobacco.

[1] Global action plan on physical activity 2018–2030: more active people for a healthier world. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272722/9789241514187-eng.pdf?ua=1, accessed 25 March 2019).

[2] Hungary. 7.4 Healthy lifestyles and healthy nutrition. In: EACEA National Policies Platform [website]. Brussels: European Commission; 2018, 27 December (https://eacea.ec.europa.eu/national-policies/en/content/youthwiki/74-healthy-lifestyles-and-healthy-nutrition-hungary, accessed 29 March 2019).

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. Following implementation of the Comprehensive Health Promotion initiative in schools, the physical activity of both boys and girls has increased over the last few years.
2. Collaboration between different sectors helped to measure the general physical condition of adolescents. For instance, the NETFIT tool showed that the childhood obesity rate was worse in 2015 than in 2014, while the running test results were better in 2015 than in 2014.
3. As schools can reach all children, adolescents and parents, they are a strategically important site for increasing awareness and boosting changes towards the adoption of healthier lifestyles for all.

Relevant HESRi[3] indicators

- Physical activity of children
- Access to green spaces
- Tobacco tax

Links to HESRi policy action areas

Living conditions

- A healthy diet is critical to reduce the risks of cancer, cardiovascular disease and other NCDs and to ensure the adoption of healthy eating habits from early childhood.
- Physical activity prevents obesity, NCDs and cancer and has a positive effect on mental health by combating depression.
- As a lack of green space can prevent people from doing physical activity, people without access to health-enabling environments are more likely to experience mental health problems and obesity.

Social and human capital

- Health literacy shapes the health behaviour of children and adolescents by reducing alcohol consumption, smoking, low physical activity and poor nutrition, which are all strongly associated with negative health outcomes.

Links to HESRi Drivers

- The Comprehensive Health Promotion initiative in schools relies on the Health in All Policies approach, in which non-health sectors are fully responsible for health outcomes in adolescents.
- The initiative is supported by the government measures and it is in line with the whole-school, whole-child, whole-society approach of Health 2020, which further strengthens the initiative as well as promoting policy coherence through joint actions.
- Health literacy empowers people by giving individuals the ability to critically engage with information to promote their health, and is thus an efficient method of reducing health inequities.

[3] The WHO European Health Equity Status Report Initiative.

Further information

Proceedings of the 3rd V4 Conference on Public Health 2017. Prague: Society of Social Medicine and Health Care Management of the Czech Medical Association of Jan Evangelista Purkyně; 2017 (https://nb.vse.cz/~DLOUHY/v4_public_health_Prague_2017_proceedings.pdf, accessed 25 March 2019).

Candari CJ, Cylus J, Nolte E. Assessing the economic costs of unhealthy diets and low physical activity. An evidence review and proposed framework. Copenhagen: WHO Regional Office for Europe; 2017 (Health Policy Series 47; http://www.euro.who.int/__data/assets/pdf_file/0004/342166/Unhealthy-Diets-ePDF-v1.pdf?ua=1, accessed 25 March 2019).

Lorenc T, Petticrew M, Whitehead M, Neary D, Clayton S, Wright K et al. A. Fear of crime and the environment: systematic review of United Kingdom qualitative evidence. BMC Public Health. 2013;13:496. doi: 10.1186/1471-2458-13-496.

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Health Services

Health & Living Conditions

Health & Social and Human Capital

Habitat-Microareas Programme in Trieste, Italy

Description of the intervention

Like many areas in the WHO European Region, Trieste (Italy) has experienced economic crises, austerity policies and high rates of unemployment over the last few decades. These factors, alongside an increasing older population (30% of the population is aged over 65 years), have resulted in higher risks of poor physical and mental health due to a lack of adequate services, financial instability and associated outcomes, such as social exclusion.

In response to these sociodemographic changes, the northern Italian region of Friuli-Venezia Giulia developed the Habitat-Microareas Programme. The Programme aims to develop local welfare plans involving several stakeholders, such as the local health agency, municipalities and the regional public housing organization; moreover, with the active involvement of local citizens being integral to the Programme.

The Programme adopts an intersectoral approach and supports coordinated activities among the health-care, social and employment sectors. Programme staff work with the local community to build and improve relationships between citizens, with the aim of fostering social cohesion and participation.

The first year of the Programme was spent getting to know the area and collecting health data. Based on this information, the strategic objectives of the Programme were identified as:

- improving health for all
- reducing health inequalities
- **improving** participatory governance for health.

The Programme implemented a set of activities of integrated care aimed at linking health-care practices to social services, housing issues and civil society networks and creating supportive environments and resilient communities.

In every microarea (with about 400–2500 inhabitants), the Programme depends on volunteers, active citizens and professionals, including:

- a full-time coordinator, usually from the Regional Health Agency, who is responsible for coordinating, integrating and monitoring health promotion and protection activities; and
- two part-time social concierges, one from the municipality's social services department and the other from the public housing organization.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The Habitat-Microareas Programme **influences** the collaboration of health-care and social services with civil society associations to improve well-being in the local population.
2. The incidence rate of admissions to hospitals for psychosis, acute respiratory infections and cardiovascular conditions decreased by 85%, 56% and 28%, respectively, after the Programme was introduced.
3. A small-scale approach is strategically important in **facilitating** the coordination of multisectoral actions and in promoting local community engagement.

Relevant HESRi[1] indicators

- Avoidable hospital admissions
- Unmet needs for health care
- Having someone to ask for help

Links to HESRi policy action areas

Health services

- As the risk of poor health is higher among people living in disadvantaged areas, the allocation of more resources to areas with greater health and social needs has a positive impact on reducing health differences among social groups and geographical areas.

Living conditions

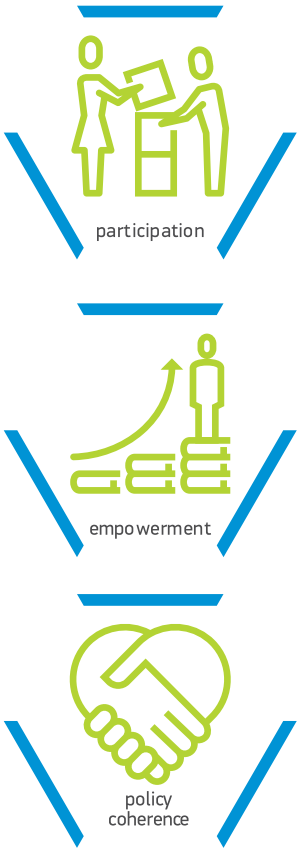
- Socioeconomically disadvantaged groups tend to live in environments characterized by high levels of deprivation and the physical deterioration of private and common spaces, and have low levels of perceived control over their health.

Social and human capital

- The planning and construction of spaces has an impact on health, as well as people's social connections and interactions.

Links to HESRi Drivers

- The Habitat-Microareas Programme **promotes** greater involvement of local residents by creating partnerships between local community members and stakeholders.
- Participating in the development of innovative solutions to daily problems empowers people by giving them a sense of control and creates stronger communities and a more equal society.
- The Programme is based on a multisectoral action in which several sectors, including the health, education and employment sectors, collaborate towards achieving agreed goals through intersectoral collaboration.



[1] The WHO European Health Equity Status Report Initiative.

Further information

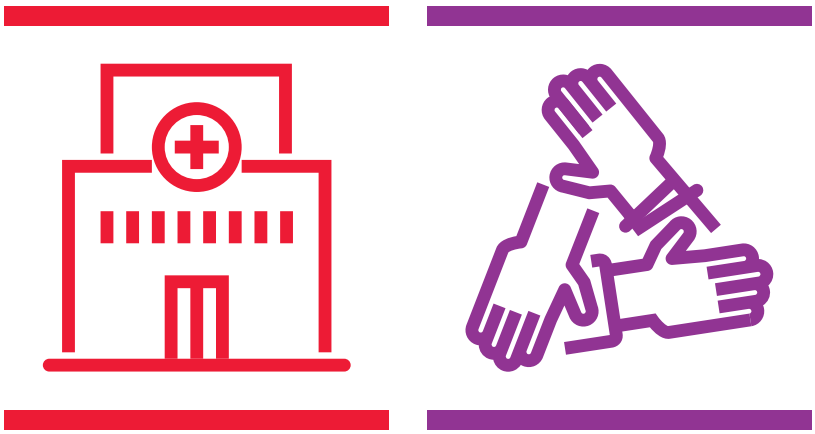
Barbone F, Castriotta L, Giangreco M. Valutazione dell'efficacia sanitaria del Progetto Microarea (MA). Report finale [Evaluation of the health effectiveness of the Microarea Project (MA). Final report]. Udine: Integrated University Healthcare of Udine; 2018 (in Italian).

Il programma Habitat-Microaree: linee di indirizzo progettuali e operative [The Habitat-Microareas programme: planning and operational guidelines]. Trieste: Integrated University Hospital of Trieste; 2018 (in Italian; http://www.asuits.sanita.fvg.it/opencms/export/sites/ass1/it/_eventi/_docs/2018/2018_007_linee_indirizzo_all_dcr1021_2018.pdf, accessed 28 February 2019).

Closing the gap in a generation. Health equity through action on the social determinants of health. Geneva: World Health Organization; 2008 (https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf; jsessionid=C540EA6740C311A49A331A6479EE0A90?sequence=1, accessed 28 February 2019).

Environmental health inequalities in Europe. Assessment report. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0010/157969/e96194.pdf?ua=1, accessed 28 February 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Health Services

Health & Social and Human Capital

PRISMA-7: detecting and mapping frailty among older people in Friuli Venezia Giulia, Italy

Description of the intervention

Frailty is one of the most concerning issues for the growing older population in the WHO European Region. Frailty develops as a consequence of age-related physiological decline and makes older adults more prone to minor physical stresses. Higher vulnerability increases the risk of adverse outcomes (e.g. falls, disability), which are associated with higher rates of hospital admission and can lead to care dependency. The Program of Research on Integration of Services for the Maintenance of Autonomy (PRISMA), funded by the University Research Centre of Quebec, the Canadian University Institute of Geriatrics and the Canadian Health Services Research Foundation, developed the PRISMA-7 questionnaire as a screening tool to identify older people who require a full assessment of frailty.[1]

In Italy, 47% of people aged 75 years and over have difficulties performing daily activities (e.g. getting dressed, cooking for themselves). Friuli Venezia Giulia, a region in north-eastern Italy, has one of the oldest populations in the European Union, with 26% of the population aged over 65 years. As many people at risk of frailty are not identified or supported by relevant institutions, Friuli Venezia Giulia adopted the PRISMA-7 tool in 2018 to detect frailty in older people and improve the response of health and social services to older people's needs. In the first year of implementation, 23 000 people in the region were contacted by telephone and interviewed about their health and level of independency.

Friuli Venezia Giulia's PRISMA-7 programme involves two phases:

- phase I consists of a screening phase to identify older people at risk of frailty through a seven question screening tool; and
- phase II confirms and evaluates the frailty conditions among the identified people and develops a local response by employing the available resources.

Early detection of the risk of frailty allows the health and social services to implement programmes focused on frailty prevention and management to reduce future hospitalization rates, **improve** outcomes and **enhance** the quality of life. In 2018 local health services in Friuli Venezia Giulia started to implement the PRISMA-7 tool in four districts. Starting in 2019 the project has been extended to all districts of the region to map the level of frailty among the entire population of Friuli Venezia Giulia and enable scaling up of the project.

In phase I of the project, local health agencies applied the questionnaire through a short telephone interview, which enabled them to:

- detect and map frailty and potential frailty among people aged 75 years and over
- develop early interventions to reduce the adverse outcomes of frailty.

In phase II local health agencies are contacting older people at risk of frailty to further discuss their conditions and ensure better-integrated support, for instance, by involving the relevant general practitioner and social services. The aim is to monitor the conditions of those at risk to:

- **improve** older people's quality of life
- **promote** independency
- **prevent** or delay hospitalization and functional dependency.

In 2018, more than 23 000 older people were interviewed, with 38% identified as potentially frail.

[1] Hébert R, Durand PJ, Dubuc N, Tourigny A, PRISMA Group. Frail elderly patients. New model for integrated service delivery. Can Fam Physician. 2003;49: 992–7.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The screening phase detects older people at risk of frailty and provides better support, thus improving their functional independence.
2. In all, 60% of those who have been contacted by telephone agreed to a telephone interview about their health conditions.
3. The collected results will inform and steer policies to better prevent and manage frailty among older people, with the aim of improving healthy life expectancy.
4. Through communication campaigns, PRISMA-7 has increased awareness of frailty across Friuli Venezia Giulia.

Relevant HESRi[2] indicators

- Limitations in the activities of daily living
- Having someone to ask for help
- Avoidable hospital admissions
- Public expenditure on long-term care

Links to HESRi policy action areas

Health services

- Frailty is not captured by traditional disease classifications or standard medical assessments. Failure to correctly tackle frailty may lead to further deterioration in older people's health and well-being.
- To ensure a comprehensive functional assessment of older people's health, it is essential to consider specific diseases and how such diseases impact and interact on health trajectories and physiological function.[3]

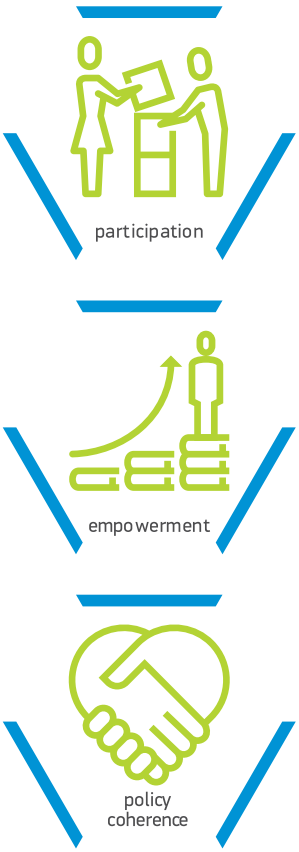
Social and human capital

- Frailty causes a progressive age-related decline in physiological systems, resulting in decreased intrinsic capacities. Ensuring integrated facilities that **support** and meet the needs of older people with limited intrinsic capacities improves health and increases health equity.

[2] The WHO European Health Equity Status Report Initiative.
[3] World report on ageing and health. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf?sequence=1, accessed 3 May 2019).

Links to HESRi Drivers

- Frail older adults and their families are high users of health-care resources. Steering policies to better meet their needs and involving them in decision-making increases their sense of control, improves their social inclusion and reduces pressures on health and social services.
- PRISMA-7 aims to detect and delay frailty to ensure longer healthier lives. By identifying the potential for frailty, older people are given the chance to be functionally independent for longer. This reduces their perceived sense of powerlessness.
- The tool relies on multisectoral collaboration between health and social services. This initiative, which is supported by the Regional Ministry of Health, Social Policies and Disability, increases policy coherence at local level by **enhancing** integrated responses to meet the real needs of the population.



Further information

Protocollo sperimentale di screening per la conduzione di un programma-intervento di sorveglianza attiva nella popolazione anziana a rischio di fragilità [Experimental screening protocol for the conduct of an active surveillance program in the elderly population at risk of fragility]. Trieste: Regional Directorate of Health, Social Policies and Disability, Friuli Venezia Giulia Region; 2018 (in Italian).

Raîche M, Hébert R, Dubois MF. PRISMA-7: a case-finding tool to identify older adults with moderate to severe disabilities. Arch Gerontol Geriatr. 2008;47(1):9–18. doi: 10.1016/j.archger.2007.06.004.

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Income Security and Social Protection

Health & Social and Human Capital

Health & Employment and Working Conditions

SELFIEmployment: supporting young people to become entrepreneurs or self-employed

Description of the intervention

Education and employment shape life trajectories and influence positive behaviours, financial stability, living conditions and life satisfaction.

Young people who are not in employment, education or training for prolonged periods are more likely to face the risks of social exclusion and depression and to take up unhealthy behaviour (e.g. drinking, smoking).[1] These factors negatively impact their health and well-being.

Among the European Union countries, Italy has the highest percentage of young people not in education, employment or training.[2] To tackle the issue, the Italian National Agency for Active Labour Policies has implemented the programme, SELFIEmployment.

The aim of the programme, which started in 2016 and is now under way, is to:

- reduce the number of young people who are not in employment, education or training
- **support** young people to become entrepreneurs or self-employed by starting a business
- provide young people with opportunities of secure and decent employment.

Several partners participate in the implementation of the programme, including all regional governments, the Ministry of Labour and Social Policies, the National Microcredit Institute, the public employment services and the National Agency for Investment and Economic Development.

SELFIEmployment is implemented through several steps.

- To access the programme, young people first need to submit a business plan through the online system.
- The business plan is then assessed according to its financial and economic sustainability.
- If the plan is eligible, successful applicants are provided with counselling, coaching and a training programme to develop the necessary skills to establish their business.

Those who are selected have access to three different types of loans:

- microcredit – up to €25 000
- extended microcredit – up to €35 000
- small loans – up to €50 000.

The loans, which are provided once the project is approved, have a 0% interest rate, are non-collateral and should be paid back within seven years.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. Since the programme began in 2016, SELFIEmployment has reached 2715 applicants and created 960 new jobs.
2. Between March 2016 and September 2018, 2250 business plans were submitted through the online system and 868 of these have been funded (total amount of €29 million).
3. Successful applicants are provided with training and coaching. By developing new skills and increasing their knowledge, they are less likely to be unemployed in the future, even if their business is not successful.

[1] UCL Institute of Health Equity. Local action on health inequalities: reducing the number of young people not in employment, education or training (NEET). London: Public health England; 2014 (Health Equity Evidence Review 3; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/356062/Review3_NEETs_health_inequalities.pdf, accessed 5 April 2019).

[2] Youth NEET rate. Geneva: International Labour Organization; 2018 (https://www.ilo.org/ilostat/faces/oracle/webcenter/portalapp/pagehierarchy/Page3.jspx;ILOSTATCOOKIE=1nFUYOT8gLJ_UF7foeK6ZqsZTMC3nOFqyFZGrYOB8OsfQNIxBKJw!-951333532?MBI_ID=20&_adf.ctrl-state=ojldaha13_57&_afrLoop=58125741978109&_afrWindowMode=0&_afrWindowId=null#!%40%40%3F_afrWindowId%3Dnull%26_afrLoop%3D58125741978109%26MBI_ID%3D20%26_afrWindowMode%3D0%26_adf.ctrl-state%3Ddm0nsfbaa_4, accessed 5 April 2019).

Relevant HESRi[3] indicators

- Young people not in employment, education or training
- Unemployment rate

Links to HESRi policy action areas

Income security and social protection

- Owing to having informal and low-paid jobs, young people are usually not entitled to the same social protection as those in standard employment. This exposes them to further risks of poor health and financial instability.[4]

Social and human capital

- Access to good-quality education and lifelong learning improves the level of educational attainments, reducing the risk of low-paid jobs or prolonged unemployment.

Employment and working conditions

- Exclusion from the labour market increases an individual's risk of mortality and diminishes their self-esteem.
- Ensuring equitable participation in secure and decent employment is a powerful approach to address health and social inequities.
- Young people not in employment, education or training are more likely to be exposed to physical hazards compared with the highest occupational groups.[5]

Links to HESRi Drivers

- SELFIEmployment gives young people the chance to become entrepreneurs or self-employed. This **influences** their power to make decisions and the perceived level of control over their destiny.
- By **increasing control** over their destinies, young people are more likely to participate in the public sphere. This enhances their social inclusion and independence while diminishing their feelings of loneliness and powerlessness.
- The programme aligns with the broader Italian strategy to reduce unemployment and relies on coordinated actions that enhances policy coherence at both the national and local levels.
- Starting a business or engaging in self-employment is increasingly seen by many countries in the WHO European Region as part of a strategy to address the challenge of youth unemployment. This represents a key policy work area for the International Labour Organization, which has supported countries in strengthening multisectoral action and increasing policy coherence.

[3] The WHO European Health Equity Status Report Initiative.
[4] Quinlan M. The effects of non-standard forms of employment on worker health and safety. Geneva: International Labour Organization; 2015 (Conditions of work and employment series No. 67; https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_443266.pdf, accessed 5 April 2019).
[5] Bambra C. Work, worklessness, and the political economy of health. Oxford: Oxford University Press; 2011.

Further information

SELFIEmployment: providing young people with microcredit/loans to support them becoming entrepreneurs or self-employed. Brussels: European Commission; 2017.

Bambra C. Yesterday once more? Unemployment and health in the 21st century. J Epidemiol Community Health. 2010;64(3):213–5. doi: 10.1136/jech.2009.090621.

O'Higgins N. Rising to the youth employment challenge. New evidence on key policy issues. Geneva: International Labour Organization; 2017 (https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_556949.pdf, accessed 5 April 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Health Services

Health & Income Security and Social Protection

Health & Social and Human Capital

Parental leave policies in Norway: the father's quota

Description of the intervention

Fair and shared parental leave policies improve women's participation in the labour market and create a fairer work–life balance for both parents.[1] A society with shared housework and childcare, equal work opportunities and equal access to social protection policies **improves** gender equity and and the well-being of both infants and parents.[2]

In the past two decades fathers' rights and obligations to care for their children have been the most important focus of parental leave policies in Norway. Promoting policies that address the critical role of men in their children's lives and development and in their family's well-being and support flexible working improves gender equality and reduces exposure to health risk factors.[3]

As part of parental leave reforms, Norway introduced the father's quota in 1993 to enhance gender equity. The father's or mother's quota is the portion of paid leave that is reserved for the father or mother. If the father does not take his parental leave, it cannot be transferred to the mother and the family loses the quota.

When parental leave rights are gender-neutral, mothers are more likely than fathers to take time off from work. However, introduction of the father's quota has led to 90% of fathers in Norway who are entitled to parental leave making use of this right. The father's quota aims to create a more gender-equal society by sharing responsibilities, opportunities and tasks between parents. It aims to:

- advance the dual earner/dual carer model, in which both parents are equally involved in work and childcare;
- encourage and enable fathers to participate in childcare and strengthen father–child relations; and
- change gender stereotypes by involving men in the nurture and care of their children.

In Norway, both the leave period and the father's quota have gradually increased (except for in 2014 when it was reduced to 10 weeks). From 1 July 2018:

- both fathers and mothers are entitled to 15 weeks of parental leave;
- the remaining portion of parental leave (16 weeks) may be shared between parents; and
- both fathers and mothers can use their parental leave quota to work on a part-time basis.

The father's quota is handled in the same way as other employment rights and regulations, in that employers allow fathers to plan their parental leave within the framework of the Working Environment Act.[4]

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. Research on parental leave found that non-transferable rights to parental leave, rather than gender-neutral rights, are more effective in getting fathers to take parental leave.
2. The father's quota has altered the traditional family model based on fathers earning and mothers caring by involving both parents in work and in childcare.
3. The father's quota connects family policies to work–life policies. This encourages gender equality by **encouraging** fathers to becomecarers and mothers to become wage-earners.

[1] Vaganay A, Canónico E, Courtin E. Challenges of work-life balance faced by working families. Brussels: European Commission; 2016 (http://www.lse.ac.uk/business-and-consultancy/consulting/assets/documents/Challenges-of-work-life-balance-faced-by-working-families.pdf, accessed 27 April 2019).
[2] Rocco L, Suhrcke M. Is social capital good for health? A European perspective. Copenhagen: WHO Regional Office for Europe, 2012 (http://www.euro.who.int/__data/assets/pdf_file/0005/170078/Is-Social-Capital-good-for-your-health.pdf?ua=1, accessed 27 April 2019).
[3] Strategy on the health and well-being of men in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0010/394894/MHR_strategy_Eng_online.pdf?ua=1, accessed 27 April 2019).
[4] Act relating to working environment, working hours and employment protection, etc. (Working Environment Act). Oslo: Ministry of Labour and Social Affairs; 2019 (https://lovdata.no/dokument/NLE/lov/2005-06-17-62, accessed 2 May 2019).

4. A gender equality policy and high levels of gender equality in society benefit men's and boys' health, leading to higher life satisfaction, fewer psychosomatic complaints and lower mortality rates.[5]

Relevant HESRi[6] indicators

- Length of paid maternity, parental and home-care leave
- Length of paid paternity, parental and home-care leave

Links to HESRi policy action areas

Health services

- Factors related to men's academic performance or employability conditions (among others) influence men's engagement with health services.

Income security and social protection

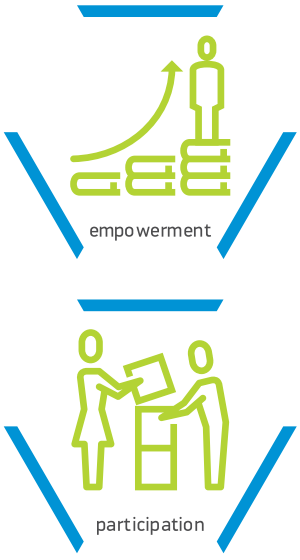
- Appropriate parental leave arrangements provide children with the best start in life.
- Paid parental leave results in higher financial security, meaning that parents with childcare responsibilities do not suffer economically and have the means to better support their child's health and development.

Social and human capital

- Appropriate and equal parental leave for both parents influences the norms of fatherhood and eliminates gender-bound educational and employment choices, which **promotes** a more equal society with equal shared opportunities.

Links to HESRi Drivers

- The father's quota empowers both men and women. It enhances equality in the workplace, improves fathers' chances of caring for their children, facilitates the father–child attachment relationship and eases the caring burden for women.[7]
- Father-specific parental leave empowers fathers to work on and develop new aspects of their masculinity.[7]
- By sharing housework and childcare, men and women gain more equal opportunities to participate in society, which **influences** individual resilience and good levels of health.[8]



[5] The health and well-being of men in the WHO European Region: better health through a gender approach. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0007/380716/mhr-report-eng.pdf?ua=1, accessed 27 April 2019).
[6] The WHO European Health Equity Status Report Initiative.
[7] Brandth B, Kvande E. Masculinity and fathering alone during parental leave. Men & Masculinities. 2018;21(1):72–90. doi: https://doi.org/10.1177/1097184X16652659.
[8] Eydal GB, Gíslason IV, Rostgaard T, Brandth B, Duvander A-V, Lammi-Taskula J. Trends in parental leave in the Nordic countries: has the forward march of gender equality halted? Community, Work & Family. 2015;18(2):167–81. doi: 10.1080/13668803.2014.1002754.

Further information

Brandth B, Kvande E. Workplace support of fathers' parental leave use in Norway. Community, Work & Family. 2019;22(1):43–57. doi: 10.1080/13668803.2018.1472067.

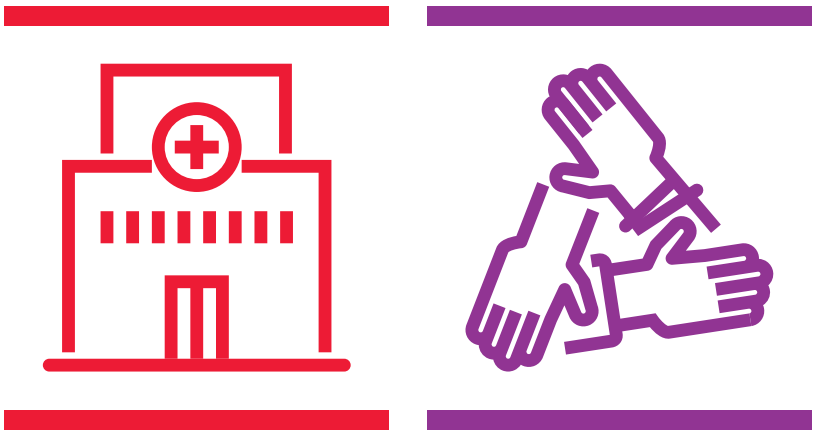
Brandth B, Duvander A-Z, Eydal GB, Gíslason J, Lammi-Taskula J, Rostgaard T. Parental leave, childcare and gender equality in the Nordic countries. Copenhagen: TemaNord, Nordic Council of Ministers; 2012 (https://www.oecd-ilibrary.org/content/publication/tn2011-562, accessed 27 April 2019).

Brandth B, Kvande E. Fathers' sense of entitlement to ear-marked and shared parental leave. Sociol Rev. 2018. doi: https://doi.org/10.1177/0038026118809002.

Women's health and well-being in Europe: beyond the mortality advantage. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0006/318147/EWHR16_interactive2.pdf?ua=1, accessed 27 April 2019).

Strategy on women's health and well-being in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0003/333912/strategy-womens-health-en.pdf?ua=1, accessed 27 April 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Health Services

Health & Social and Human Capital

The Healthy Generation Project in the Republic of Moldova

Description of the intervention

In the WHO European Region, more than 300 young people die every day from largely preventable causes linked to the increased use of alcohol, binge-drinking, road traffic injuries, suicides and chronic conditions. This results in a growing demand for health care.

In the Republic of Moldova, young people face multiple challenges regarding their health, well-being and access to health-care services. The Moldovan Government has prioritized the health and development of young people in several strategic policy documents to increase their access to health information and to high-quality youth-friendly health services (YFHS).

The nongovernmental organization Health for Youth, with support from the Ministry of Health, Labour and Social Protection, implemented the Healthy Generation Project[1] to **scale up** YFHS in all 35 districts of the country. The project has been financially supported by the Swiss Agency for Development and Cooperation and UNICEF Moldova and it was implemented in cooperation with a wide range of actors, including the Ministry Health, Labour and Social Protection; the Ministry of Education, Culture and Research; local authorities; civil society organizations; WHO; the United Nations Educational, Scientific and Cultural Organization (UNESCO).

The Project aims to:

- **increase** the demand for, access to and utilization of high-quality YFHS
- **improve** health-related information and knowledge to enhance health literacy among young people
- **improve** the quality of health services for adolescents and young people aged 10–24 years
- **increase** health and well-being among young people
- **prioritize** the needs of young people.

Youth-friendly health centres improve the health and well-being of young people and accelerate actions toward groups at most risk, including those who are socially and economically vulnerable. Youth-friendly health centres:

- provide a package of health services to tackle a wide range of problems, such as sexual and reproductive health, nutritional disorders, mental health problems and problems resulting from violence; and
- deliver health services, including mental health services (information and counselling), sexual health services (provision of contraceptives) and general medical examinations.

The United Nations Children's Fund and Health for Youth implemented the Project in three phases.

- Phases I (2011–2013) and II (2014–2018) scaled up YFHS at national level.
- Phase III (2019–2020) is currently focusing on the sustainability of YFHS to ensure their continuing function after the end of the Project.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The Healthy Generation Project has helped to establish 41 youth-friendly health centres around the country, which are integrated into the primary health-care system.
2. Young people are increasingly using YFHS – 5% of young people in the Republic of Moldova accessed YFHS in 2011 and 24.5% in 2017.
3. Intersectoral collaboration between international organizations, several ministries and the broader community has delivered a comprehensive strategy to tackle the health and well-being of young people.

[1] Project "healthy generation". Bern: Swiss Agency for Development and Cooperation; 2015 (https://learningeventhealth.files.wordpress.com/2015/11/healthy-generation-en.pdf, accessed 9 May 2019).

4. Data show an increasing demand from young people and improved communication between adolescents and youth-friendly health centre professionals.

Relevant HESRi[2] indicators

- Self-reported social support in young people
- Self-reported unmet need for health care

Links to HESRi policy action areas

Health services

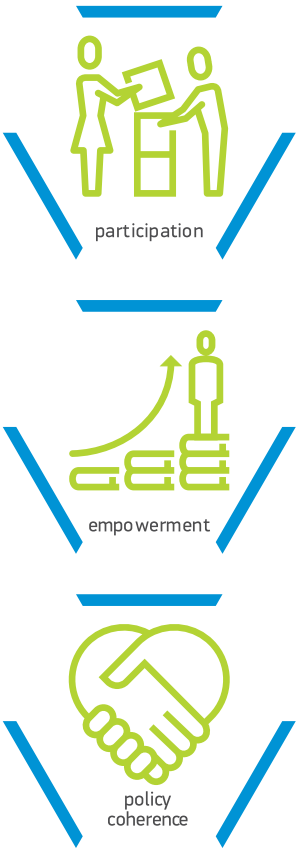
- Providing high-quality, accessible YFHS reduces the unmet need for health care in young people.

Social and human capital

- Scaling up youth-friendly health centres has a positive effect on health literacy because the centres improve health promotion and access to health information.
- Health literacy and the ability to critically engage with information to promote health improves young people's health and well-being. For instance, it may reduce sexually transmitted infections by increasing safe sexual behaviour.

Links to HESRi Drivers

- Youth-friendly health centres provide young people with training and health-related education programmes, which enhance their participation in health promotion and care.
- YFHS empower young people by improving their health literacy, which strengthens their ability to gain access to, understand and use information in ways that promote and maintain good health and well-being.
- Youth-friendly health centres make young people more likely to access health care by improving geographical access and diminishing legal barriers and stigma, which young people may face when dealing with issues such as drug addiction or unwanted pregnancy.
- Several actors, including ministries, civil society organizations and local authorities, collaborate in the Healthy Generation Project to increase access to health information and high-quality YFHS for young people. This approach enhances policy coherence at national level.



[2] The WHO European Health Equity Status Report Initiative.

Further information

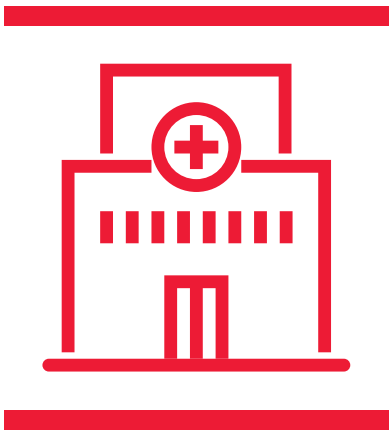
Carai S, Bivol S, Chandra-Mouli V. Assessing youth-friendly-health-services and supporting planning in the Republic of Moldova. Reprod Health. 2015;12:98. doi: 10.1186/s12978-015-0088-6.

SDC. Youth-friendly health services (YFHS). Bern: Swiss Agency for Development and Cooperation; 2015, August (Project Factsheet; https://www.eda.admin.ch/dam/deza/en/documents/aktuell/agenda/20150813-factsheet-projekt-YFHS_EN.pdf, accessed 9 May 2019).

Kempers J, Ketting E, Lesco G. Cost analysis and exploratory cost–effectiveness of youth-friendly sexual and reproductive health services in the Republic of Moldova. BMC Health Serv Res. 2014;14:316. doi: 10.1186/1472-6963-14-316.

Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/255415/9789241512343-eng.pdf?sequence=1, accessed 9 May 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Health Services

Baby-friendly Hospital Initiative in the Russian Federation

Description of the intervention

Breastfeeding reduces child mortality and has health benefits that extend into adulthood. In the last few years, the mortality rate has decreased for children aged under 5 years in the Russian Federation. At the same time breastfeeding has increased in 53 out of the 85 Russian regions that have adopted the Baby-friendly Hospital Initiative (BFHI).

The BFHI aims to protect, **promote** and support breastfeeding in the Russian Federation to give every baby the best start in life by creating a health-care environment in which breastfeeding is the norm. It:

- **enables** mothers to make an informed choice about how to feed their newborns
- **supports** the early initiation of breastfeeding
- **ensures** that supplies of free, low-cost infant formula to hospitals ceases
- **provides** additional information on mother and infant health-care issues, such as HIV.

Many interventions have been developed to support the BFHI, such as SMS-to-Mum and the Neo-BFHI Package. These interventions are guided by the following principles:

1. staff focus on the mother and her situation on a case-by-case basis
2. the facility provides family-centred care
3. the health-care system must ensure continuity of care from pregnancy to after the infant's discharge.

SMS-to-Mum provides useful information to pregnant women and young mothers on how to care for their health using a mobile connection and the Web. This communication channel, developed by experts in the sphere of obstetrics and neonatology, includes weekly short text messages on several health topics, infographics and, real-time webinars.

The BFHI provides mothers with:

- breastfeeding counselling
- information on their health
- general support on how to breastfeed.

To implement this practice among all countries, in 2018 the BFHI revised their guidance document, *Ten steps to successful breastfeeding*, emphasizing strategies to scale up and integrate the programme into the entire Russian health-care system. The aim is that all facilities in the country implement the Ten steps, thus ensuring it is accessible to everyone in the different geographical areas of the Russian Federation.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. As a result of implementing the BFHI, breastfeeding of 6–12-month-old babies in the Russian Federation has increased sharply.
2. Increasing the breastfeeding rate has contributed to the decrease in infant mortality and morbidity rates in the Russian Federation.

Relevant HESRi[1] indicators

- Infant mortality rate
- Life expectancy at birth
- Self-perceived quality in health care

[1] The WHO European Health Equity Status Report Initiative.

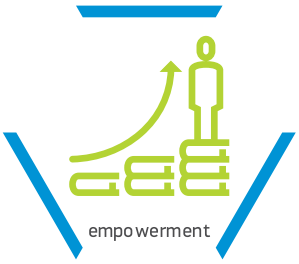
Links to HESRi policy action areas

Health services

- In addition to improving child survival and protecting against life-threatening and chronic illnesses, breastfeeding promotes healthy growth and improves early child development, including healthy brain development.
- Breastfeeding also benefits mothers because it protects against postpartum haemorrhage, ovarian and breast cancer, postpartum depression, and heart disease.

Links to HESRi Drivers

- Empowering women gives them an increased sense of control over their health.



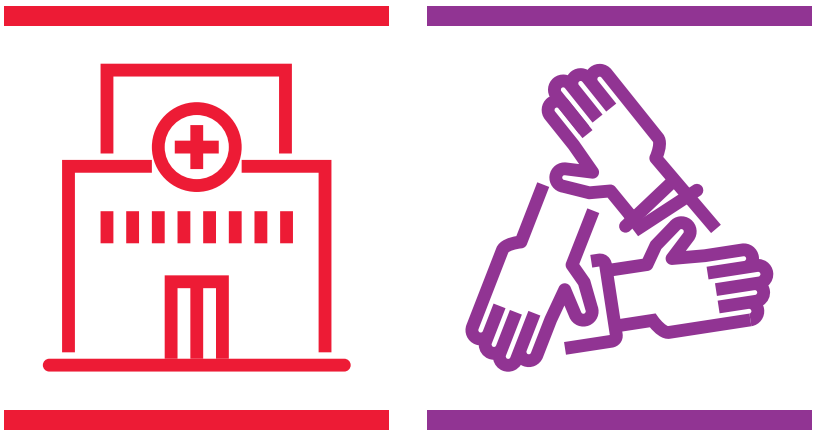
Further information

United Nations Children's Fund, World Health Organization. Implementation guidance. Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-Friendly Hospital Initiative. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272943/9789241513807-eng.pdf?ua=1, accessed 25 March 2019).).

Breastfeeding: a mother's gift, for every child. New York: United Nations Children's Fund; 2018 (https://www.unicef.org/publications/files/UNICEF_Breastfeeding_A_Mothers_Gift_for_Every_Child.pdf, accessed 25 March 2019).

World Health Organization, United Nations Children's Fund. Advocacy brief. Breastfeeding and gender equality. New York: United Nations Children's Fund: 2018 (https://www.unicef.org/nutrition/files/6._Advocacy_Brief_on_BF_and_Gender_Equality.pdf, accessed 25 March 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Health Services

Health & Social and Human Capital

This is Me: mental health programme for youth, Slovenia

Description of the intervention

Adolescence is a transitional stage of development: teenagers often experience poor support, low levels of self-confidence and self-respect and difficulties with social and communication skills. These factors may have a negative impact on mental health and well-being.

With the support of the National Institute of Public Health of Slovenia, the This is Me Programme helps to improve mental health in adolescents by developing positive and realistic self-esteem, social and emotional skills, and other competencies to **support** them in their everyday lives.

The Programme is informed by issues which adolescents have identified as important and consists of an online counselling service and school-based prevention activities.

The online counselling service, This is Me,[1] supports adolescents by:

- providing friendly, simple, fast, free, anonymous and efficient expert information and problem-solving advice;
- giving them continual support with everyday problems; and
- offering a multidisciplinary online counselling network, which includes over 50 volunteer experts, including medical doctors of various specialities, psychologists, and educators.

School-based prevention activities are based on 10 workshops and two manuals.

- The teacher's manual aims to build personal strength and resilience by working with small groups of adolescents in the classroom for the entire series of 10 workshops. Young people learn about accepting themselves and others, asserting themselves in relation to others, understanding their own emotions, developing a realistic outlook on various situations and adopting an active-approach to problem-solving.
- The adolescent's manual aims to support adolescents by providing examples of web dialogues between adolescents and experts about the typical problems young people face.

The programme has been developed and upgraded over many years and provides a comprehensive, evidence-based model for contemporary school mental health promotion.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. This is Me is a cost-effective measure to tackle adolescents' mental health and well-being. Since the beginning of the Programme in 2001, experts have answered over 42 000 questions about the dilemmas and problems faced by teenagers, with most questions answered in less than five days.
2. Qualitative and quantitative evaluation of school-based prevention workshops indicated that the Programme had positive effects, most notably on improving teacher–student relationships.

Relevant HESRi[2] indicators

- Self-reported unmet need for health care
- Having someone to ask for help

[1] Tosemjaz [This is me] [website]. Ljubljana: National Institute of Public Health; 2016 (http://www.tosemjaz.net/, accessed 13 March 2019).
[2] The WHO European Health Equity Status Report Initiative.

Links to HESRi policy action areas

Health services

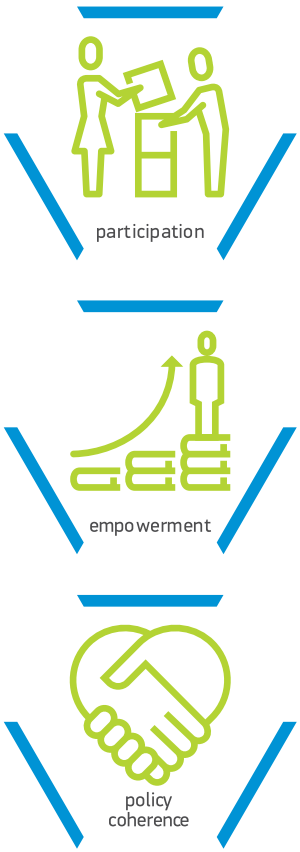
- Half of all mental health conditions occur before 14 years of age,[3] yet most cases are undetected and untreated. These mental health conditions often reappear during adulthood and have further impacts on physical and mental health.
- Comprehensive, long-term care in schools to promote better mental health in children and adolescents is an effective way to reach all adolescents and **prevent** mental health problems in young people from becoming problems in adulthood.

Social and human capital

- Supportive environments in schools, families and communities are essential to improve mental health conditions among adolescents.
- Action in the school environment to tackle discrimination, social exclusion, isolation and socioeconomic problems linked to mental health conditions reaches adolescents regardless their socioeconomic background.

Links to HESRi Drivers

- Participation in mental health discussions **enhances** social cohesion and inclusion among teenagers who, by focusing on their strengths and resources, reinforce their resilience.
- This is Me supports adolescents in building personal resilience through developing basic life skills, which make them more likely to cope well in health and in life.[4]
- This is Me empowers youth because it focuses on tackling mental health problems when they begin in order to prevent these problems in the future.
- The Programme relies on integrated, comprehensive and coordinated actions for mental health promotion by the health and education sectors towards the same agreed goal. This is Me is an example of policy coherence, whereby where two sectors work together to reduce health inequities.
- This is Me is in line with the Slovene National Mental Health Programme 2018–2028,[5] which supports intersectoral actions towards improving adolescents' mental health.



[3] Mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf?sequence=1, accessed 6 March 2019).
[4] Social cohesion for mental health and well-being among adolescents. Copenhagen: WHO Regional Office for Europe; 2008 (http://www.euro.who.int/__data/assets/pdf_file/0005/84623/E91921.pdf, accessed 6 March 2019).
[5] Resolucijoo nacionalnem programu duševnega zdravja 2018–2028 [Resolution to the national mental health programme 2018–2028]. Government of the Republic of Slovenia; 2018 (in Slovene; ReNPDZ18-28; http://www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/NOVICE/28032018_ReNPDZ18-28.pdf, accessed 13 March 2019).

Further information

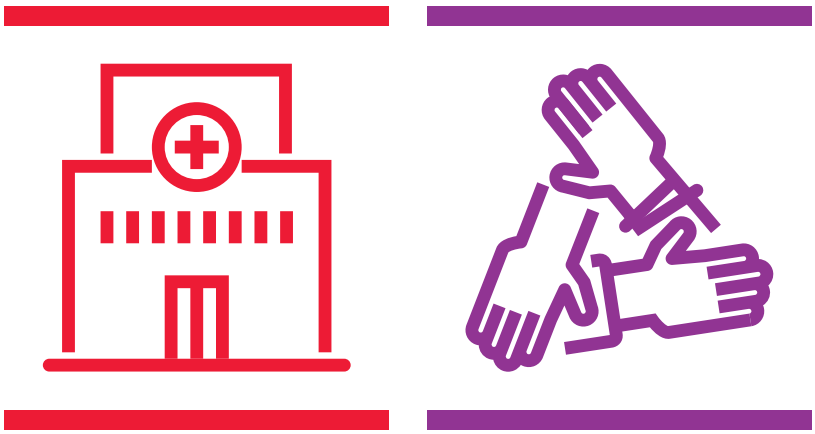
Promotion and prevention in mental health: strengthening parenting and enhancing child resilience. Rockville (MD): Substance Abuse and Mental Health Services Administration Center for Mental Health Services; 2007 (https://store.samhsa.gov/system/files/svp07-0186.pdf, accessed 6 March 2019).

Public health workforce development. In: 11th European Public Health Conference. Eur J Public Health. 2018;28(4) (https://academic.oup.com/eurpub/issue/28/suppl_4, accessed 6 March 2019).

Lekić K Juričič NK, Cugmas M. Online counselling as a modern paradigm of additional support during growing up. In: Proceedings. International Scientific Conference: Healthonline, Ljubljana, Slovenia, 27 January 2017 (http://www2.zf.uni-lj.si/si/zborniki/product/view/3/96, accessed 6 March 2019).

Good practices in mental health and well-being: mental health at work, in schools, prevention of depression and suicide. Brussels: European Commission; 2017 (https://ec.europa.eu/health/sites/health/files/mental_health/docs/2017_mh_work_schools_en.pdf, accessed 6 March 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Health Services

Health & Social and Human Capital

Promoting health for all through health promotion centres in Slovenia

Description of the intervention

People from lower socioeconomic backgrounds have more difficulties in accessing health care and often experience higher unmet health-care needs compared with those on middle and high incomes.[1] This results in differences in life expectancy and healthy life expectancy between the poorest and richest populations.

Despite universal and comprehensive health care access for all Slovene citizens, inequities in noncommunicable disease (NCD) outcomes exist across regions in Slovenia, reflecting the different levels of development and poverty. Socioeconomic conditions significantly affect lifestyle, leading to differences in health across population groups.[2]

To reduce the key risk factors for NCDs among those with the fewest resources, the Slovene Government has set up health promotion centres (HPCs) in primary health-care centres across the country. The HPCs integrate primary care and public health services and engage with other public services and governmental and nongovernmental organizations (NGOs) in the local area to address multiple needs.

The Health Promotion for All project is implemented in 25 HPCs and aims to improve health and quality of life for all at community level. Several teams responsible for health promotion and preventive care activities work in professional, school and preschool environments. The implemented activities aim to:

- **strengthen** the public health role of primary health-care centres (e.g. health promotion activities);
- reduce the burden of chronic diseases in children, adolescents and adults; and
- introduce the community approach model for **promoting** health and reducing health inequality in local communities.

To meet its objectives, the project promotes integrated multisectoral actions among the health, social and education sectors, municipal services and NGOs.

The activities include:

1. preparing new parents for childbirth and parenting through health promotion activities (e.g. related to breastfeeding, the postnatal period, partner relationships);
2. health promotion and preventive care activities for children, adolescents and parents (e.g. upgraded preventive health check-ups; promotion of mental health, healthy nutrition, physical activities);
3. a health promotion programme for adults (including physical fitness testing, relaxation techniques, healthy lifestyle activities); and
4. activities for promoting health and reducing health inequality in local communities (e.g. encouraging participation through workshops/lectures).

Alongside these activities, the project provides local communities with direct support from professionals in patients' homes, with the aim to **encourage** elderly, ill and frail individuals to stay in their home environment as long as possible.

To further encourage interprofessional and intersectoral coordination among local actors, a Local Health Promotion Group has been established in every area. It consists of representatives of municipalities, institutions from the health and social sectors, educational institutions and various NGOs, which together respond to the needs of the community and reduce health inequities.

[1] Poverty, social exclusion and health systems in the WHO European region. Copenhagen: WHO Regional Office for Europe; 2010 (http://www.euro.who.int/__data/assets/pdf_file/0004/127525/e94499.pdf?ua=1, accessed 24 June 2019).
[2] Buzeti T, Djomba JK, Blenkuš MG, Ivanuša M, Klanšček HJ, Kelšin N et al. Health inequalities in Slovenia. Ljubljana: National Institute of Public Health; 2011 (https://pdfs.semanticscholar.org/8136/e658c90f3c2246b39d40bb773a51dde75941.pdf, accessed 24 June 2019)

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. An integrated approach to care enables a rapid identification and response to the population's needs.
2. Additional preventive activities reduce future hospitalizations.
3. Better collaboration with the social sector, NGOs and educational institutions reduces barriers in accessing the health-care systems, especially for people with physical and sensory impediments.
4. Upgrading preventive examinations of children, adolescents and adults ensures the early detection of those at risk of developing chronic diseases.

Relevant HESRi[3] indicators

- Public expenditure on health
- Avoidable hospital admissions
- Self-perceived quality in health care

Links to HESRi policy action areas

Health services

- Providing all areas with HPCs make residents more likely to access services and reduces unmet health-care needs.
- Reducing risk factors for NCDs (e.g. tobacco use, physical inactivity, unhealthy diet) through awareness-raising activities, health check-ups and workshops reduces health inequities.[4]

Social and human capital

- Health promotion programmes for children and adults **increase** their level of health literacy, which has positive impacts on individuals' quality of life by influencing health behaviours.
- Health literacy **empowers** individuals and gives them a more active role in decision-making and management related to their health.[5]

[3] The WHO European Health Equity Status Report Initiative.
[4] Petrič V, Pribakovic Brinoveć R, Maučec Zakotnik J. Health promotion centres in Slovenia: integrating population and individual services to reduce health inequalities at community level. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0004/377428/hss-ncd-policy-brief-slovenia-eng.pdf?ua=1, accessed 24 June 2019).
[5] Nutbeam D. Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. Health Prom Int. 2000;15(3):259–67. doi: https://doi.org/10.1093/heapro/15.3.259.

Links to HESRi Drivers

- Setting up HPCs at local level strengthens the community's resilience and empowers citizens from lower socioeconomic backgrounds.
- By introducing a community-based approach model to health promotion and preventive care, individuals are more likely to participate in society and take part in health-related activities through workshops and lectures.
- The Health Promotion for All project has an integrated structure based on multisectoral actions. Policy coherence and the accountability of the strategy are further strengthened by the Local Health Promotion Group, which coordinates actions and clarify roles and responsibilities.

Further information

Magajne M, Dobrin PT, Maučec Zakotnik J. Towards better health and reducing inequalities in health together for health. Ljubljana: National Institute of Public Health; 2018 (http://www.skupajzazdravje.si/media/publikacija.projekta.skupaj.za.zdravje_ang_l.pdf, accessed 24 June 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Income Security and Social Protection

Health & Living Conditions

Health & Social and Human Capital

The B-Mincome project: providing low-income families in Barcelona, Spain with financial support and social benefits

Description of the intervention

People from lower socioeconomic backgrounds tend to live in environments with fewer resources, low-quality public spaces and higher rates of crimes. These factors impact the health and well-being of residents, who are more likely to experience poorer living conditions compared with people from high-income areas.[1,2]

In the last few years, the increased level of poverty in Barcelona has affected some areas more than others. Income inequalities have also increased: while the income of the poorest population has decreased by 27%, that of the richest population income has increased by 11%.[3]

To ensure that all citizens have a good standard of living regardless of the neighbourhood they live in, Barcelona City Council implemented B-Mincome, a two-year pilot project (2017–2019), in the Eix Besòs area. This area is characterized by a lower average income, high unemployment rates, and high rates of school failure and school dropouts. The B-Mincome project is part of the wider municipal agenda to fight poverty and socioeconomic and territorial inequities in Barcelona and is implemented by several stakeholders, including the Social Rights Department of Barcelona City Council (which leads the project), the Young Foundation, the Institute of Governance and Public Policy of the Autonomous University of Barcelona, the Polytechnic University of Catalonia, the International Institute for Nonviolent Action and the Catalan Institute for Public Policy Evaluation.

The B-Mincome project aims to invest in people and improve their immediate surroundings by providing a guaranteed minimum income. A minimum income is about not only monetary values but also emancipatory and social values: it **enables** people to live healthy lives. The project has implemented several measures to improve the socioeconomic situation of participating households.

- Several programmes implemented in the Eix Besòs area aim to increase incomes and help families lift themselves out of poverty by increasing employment opportunities for unemployed people, increasing the general standard of living by renovating houses, and enhancing social and cooperative activities in low-income neighbourhoods.
- Other families participate in activities to increase engagement with their community and their sense of belonging to the neighbourhood.
- A local currency was introduced in low-income neighbourhoods to **encourage** citizens to buy from local businesses and thus benefit the local economy.

These measures provide low-income families with a guaranteed minimum income and non-financial support, thereby giving them the tools and means to exit the cycle of poverty.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. This innovative project is testing the effectiveness of both financial and non-financial (e.g. social benefits) support in 10 deprived neighbourhoods to reduce inequities and **create** healthy-enabling environments, thereby reducing poverty-related stress and mental illness.
2. By **accelerating** actions to improve the socioeconomic conditions of 1000 people living in a low-income area, the B-Mincome project focuses on increasing equity.

[1] Community development in Europe: towards a common framework and understanding. European Union Community Development Network; 2014 (http://eucdn.net/wp-content/uploads/2014/10/EuCDN-Publication_FINAL.pdf, accessed 3 May 2019).
[2] Heller J. A framework connecting criminal justice and public health. Oakland (CA): Human Impact Partners; 2016 (https://humanimpact.org/a-framework-connecting-criminal-justice-and-public-health, accessed 3 May 2019).
[3] Data source: Barcelona City Council.

3. The project aims to improve the financial stability of low-income families and give them the means and tools to exit the cycle of poverty.

Relevant HESRi[4] indicators

- Poverty
- Satisfaction with the living environment
- Social protection expenditure
- Vulnerable people covered by social assistance programmes

Links to HESRi policy action areas

Income security and social protection

- Providing a minimum income to those with limited resources has a health-promoting effect. It reduces poverty, reduces anxiety and stress levels and provides wider protection that safeguards individuals from misfortunes such as unemployment, homelessness and ill health.

Living conditions

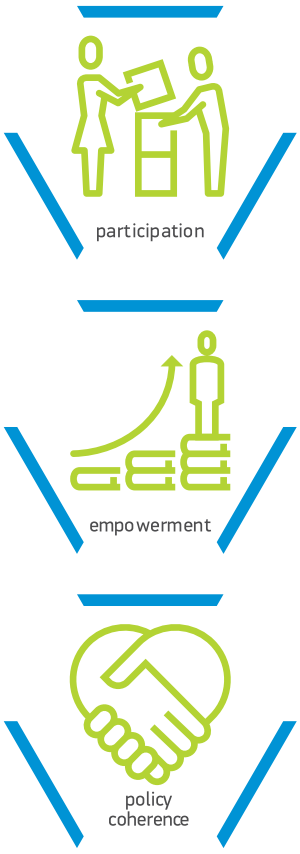
- People from a lower socioeconomic background are less likely to live in a health-enabling environment. This further impacts their perceived degree of control and their psychosocial stress levels.

Social and human capital

- Active policies that ensure appropriate and equitable shared opportunities for education, learning and employment have a significant impact on health, well-being and community prosperity.

Links to HESRi Drivers

- Active socio-occupational policies **encourage** individuals' participation in the community, create employment opportunities and improve the standard of living. This type of support enables the **prevention**, not just the alleviation, of poverty.
- Alleviating poverty among those from lower socioeconomic backgrounds **empowers** the whole community and increases people's participation and trust in the community.
- Investing in people improves their immediate surroundings and neighbourhoods, **enabling** citizens from lower socioeconomic background to develop **greater** self-determination and **more control** of their own well-being.
- The wide range of stakeholders involved in implementing the B-Mincome project strengthens policy coherence and ensures the accountability of the project.
- The B-Mincome project is aligned with the **Europe 2020 strategy for smart, sustainable and inclusive growth**, which aims to reduce poverty and social exclusion by 2020. This further improves the policy coherence of the initiative, which is built on multisectoral effort.



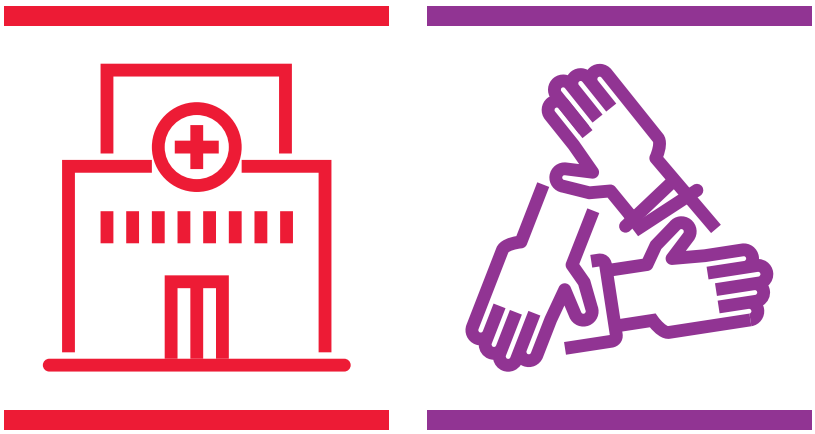
[4] The WHO European Health Equity Status Report Initiative.

Further information

Colini L. The B-MINCOME project. Project led by the City of Barcelona. Lille: Urban Innovative Actions; 2017 (https://www.uia-initiative.eu/sites/default/files/2017-12/FINAL%20VERSION_Barcelona.pdf, accessed 3 May 2019).

Lundberg O, Dahl E, Fritzell J, Palme J, Sjöberg O. Social protection, income and health inequities. Final report of the Task Group on GDP, Taxes, Income and Welfare. Review of social determinants of health and the health divide in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0006/302874/TG-GDP-taxes-income-welfare-final-report.pdf?ua=1, accessed 3 May 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Health Services

Health & Social and Human Capital

Disability and rehabilitation in Tajikistan: development of a multisectoral national programme to leave no one behind

Description of the intervention

Persons with disabilities have poorer overall health compared with the general population and their health needs more often remain unmet.[1] Rehabilitation services **maximize** people's ability to work, learn and participate in the society,[2] and are essential for meeting the needs of people with different health conditions, including acute or chronic diseases, disorders, injuries and disabilities.

In 2010 Tajikistan experienced an outbreak of poliomyelitis (polio) caused by the population not being adequately vaccinated against the disease. Given the irreversible impairments that polio can lead to, Tajikistan **scaled up** rehabilitation services and access to assistive products to minimize polio's negative effects and to tackle other disabling health conditions (e.g. caused by noncommunicable disease).

Since 2013 WHO has collaborated with the Ministry of Health and Social Protection of Tajikistan to implement a disability and rehabilitation programme in the country. The programme consists of two phases:

1. in phase I (2013–2016) the Ministry and WHO jointly developed national policies, systems and services for rehabilitation; and
2. in phase II (2016–2019) the Ministry and WHO worked together to improve access and deliver better-quality rehabilitation services.

To improve rehabilitation services, the Ministry of Health and Social Protection collaborated with several stakeholders, including representatives of the Ministry of Labour, Education and Science; national and international nongovernmental organizations; development partners; and disabled people's organizations. Several actions have been implemented during the two phases of the programme:

- Rehabilitation camps were set up in strategic geographical areas to improve equitable access to rehabilitation services and provide professionals (e.g. therapists, physiotherapists, rehabilitation specialists) with advanced training in person-focused rehabilitation services and capacity-building activities.
- The assistive technology sector and its services were strengthened to provide people with health conditions to have access to different assistive products (e.g. wheelchairs, hearing aids) to maximize their functioning, independence and participation in society.
- Long-term training programmes outside the country were provided for health professionals with the aim to strengthen rehabilitation services and build rehabilitation capacity throughout the country in the long term to reduce the unmet needs for health.
- National conferences, guidelines and other products were developed to promote the development of community-based rehabilitation programmes, with the aim to improve access to rehabilitation services in rural and remote areas and minimize the negative impact of impairments.

Following intersectoral collaboration between the Ministry of Health and Social Protection and local stakeholders, the Government of Tajikistan **created** an inter-ministerial working group, which drafted a four-year national rehabilitation programme (2017–2020) for persons with disabilities that was adopted by the Government in 2016. This is the first normative document on disability in Tajikistan.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. Improvement in rehabilitation services has reduced the barriers faced by people with short- and long-term impairments. More than 170 000 people with long-term impairments (59% of people with chronic diseases), as well as people with difficulties in functioning caused by injuries or frailty, are benefiting from the improvements of rehabilitation services.

[1] World Health Organization, World Bank. Summary: world report on disability. Geneva: World Health Organization; 2011 (https://www.who.int/disabilities/world_report/2011/accessible_en.pdf, accessed 13 May 2019).
[2] Rehabilitation in health systems. Geneva: World Health Organization; 2017 (Licence: CC BY-NC-SA 3.0 IGO; http://apps.who.int/iris/bitstream/handle/10665/254506/9789241549974-eng.pdf;jsessionid=16603A8AE18B8B4A1B5B900C66E37A92?sequence=1, accessed 13 May 2019).

2. Since 2016 community-based rehabilitation programmes have been established in 35 out of 66 districts, representing strategic areas to reach the largest possible number of people and extend the coverage of existing service providers. More than 6200 people with disabilities in rural areas have benefited from the programmes.
3. The programme has contributed to strengthening health systems and to **accelerating** progress towards the achievement of universal health coverage by increasing access to health services for people with long-term and temporary impairments and thereby minimizing the impact of these conditions.
4. By promoting an inclusive society in which individuals can enjoy equal opportunities, rehabilitation services for people with disabilities represent an investment in social capital, which contributes to health, social and economic development.

Relevant HESRi[3] indicators

- Avoidable hospital admissions
- Prevalence of self-reported cardiovascular diseases
- Disability employment gap
- Self-reported unmet need for health care

Links to HESRi policy action areas

Health services

- Rehabilitation is an integral component of health services that enables people to realize their functional potential in the environment in which they live and work.[4]
- Improving rehabilitation and access to assistive products expedites hospital discharge and prevents readmission.
- Increasing community-based rehabilitation services reduces barriers for those living in rural areas and reduces their unmet needs for health.
- Providing health professionals with formal training improves the quality of rehabilitation services.

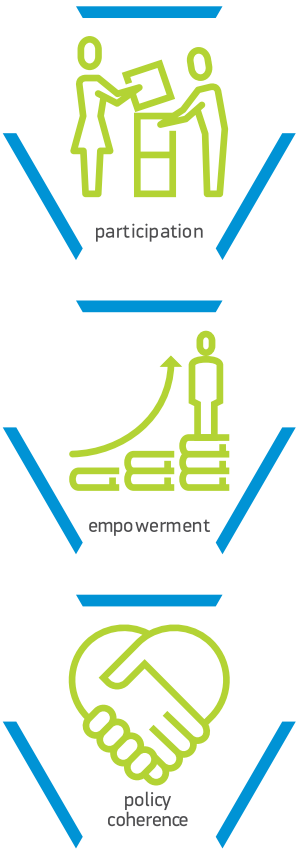
Social and human capital

- Without appropriate rehabilitation services and access to assistive products, people with disabilities may be unable to participate in their community, in education and in the labour market and may experience restricted mobility.
- Rehabilitation programmes minimize the impact of impairment and maximize people's functioning, independence and participation in society.

[3] The WHO European Health Equity Status Report Initiative.
[4] Rehabilitation in health systems. Geneva: World Health Organization; 2017 (Licence: CC BY-NC-SA 3.0 IGO; http://apps.who.int/iris/bitstream/handle/10665/254506/9789241549974-eng.pdf;jsessionid=16603A8AE18B8B4A1B5B900C66E37A92?sequence=1, accessed 13 May 2019).

Links to HESRi Drivers

- The provision of rehabilitation services and assistive products represents an investment in human capital, which is an important component of universal health coverage and **creates a more inclusive society**.
- The creation of community-based rehabilitation services **empowers** people with disabilities and reduces the barriers they face in accessing health services.
- WHO supported the Ministry of Health and Social Protection to develop a position paper on better health for persons with disabilities by helping the health sector to understand its roles and responsibilities to improve access to rehabilitation services for all people, including those with disabilities or chronic conditions and elderly people.
- Multisectoral collaboration between different stakeholders and sectors enhances **policy coherence** for the programme. While the health sector is responsible for providing rehabilitation programmes and assistive products, the social sector facilitates the participation of people with disabilities and health conditions in society. Alignment with the United Nations Convention on the Rights of Person with Disabilities (which Tajikistan signed in March 2018) further strengthens policy coherence for the programme.



Further information

Mishra S, DeMuth S, Sabharwal S, Watts HG, Lentz KL, Huber M et al. Disability and rehabilitation in Tajikistan: development of a multisectoral national programme to leave no one behind. Pub Health Panorama. 2018;4(2):147–271.

Strengthening the skills of rehabilitation personnel in Tajikistan. Copenhagen: WHO Regional Office for Europe; 2014, 11 December (http://www.euro.who.int/en/countries/tajikistan/news/news/2014/12/strengthening-the-skills-of-rehabilitation-personnel-in-tajikistan, accessed 13 May 2019).

Ministry of Health and Social Protection of Tajikistan, WHO Regional Office for Europe. Situational analysis: state of rehabilitation in Tajikistan. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/__data/assets/pdf_file/0009/276480/State-Rehabilitation-Tajikistan-Report-en.pdf, accessed 13 May 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Living Conditions

Achieving sustainable food and nutrition security in rural areas in Tajikistan

Description of the intervention

Malnutrition is the leading cause of ill health in Tajikistan.[1] Despite significant steps by the Tajik Government to address this problem, malnutrition continues to negatively impact the population's health and well-being, particularly for women, infants, children and adolescents. As access to affordable, nutritious and health-promoting food is more likely to affect lower socioeconomic groups (who are disproportionately affected through lacking access to such foods), food security is critical to health equity.[2]

The different forms of malnutrition are undernutrition, overweight and micronutrient-related malnutrition. Malnutrition is significantly higher in Tajikistan than in neighbouring countries in central Asia. A survey conducted by the World Food Programme in 2017 found that in Tajikistan 20% of children aged under 5 years were malnourished and 31% were stunted.[3] Micronutrient deficiencies were common among the general population, in particular among children. More than one third of children had a vitamin A deficiency, while the prevalence of zinc deficiency and irreversible iron deficiency in children was approximately 70%.[4] Malnutrition, together with water shortages and the scarcity of agricultural land, have made Tajikistan extremely vulnerable to external shocks.

Given the large disparity in the rates of stunting and malnutrition between rural and urban areas, the non-profit-making organization Welthungerhilfe Tajikistan sought to change the livelihoods of people in the rural areas of northern Tajikistan, which is characterized by adverse climate conditions and strong dependence on a small-plot subsistence economy. Welthungerhilfe Tajikistan is working to **improve** natural resource management (NRM) in the area to ensure food and nutrition security and **achieve** sustainable poverty reduction through the Sustainable Food and Nutrition Security project. The project is funded by the European Union in the frame of the Rural Development Programme 1/ Tajikistan. The project, implemented by a consortium, is led by Welthungerhilfe in coordination with the Ministry of Health and Social Protection and different departments in local government.

This multisectoral approach ensures the integration of activities. Since 2016 the project has implemented actions to:

- **enhance** natural resources techniques – farmers have received training on improved energy supplies, water preservation, soil management, soil erosion control and awareness-raising campaigns on the efficient use of water resources and rainwater harvesting techniques;
- **foster** collaboration between farmers to improve NRM – the project supports **inclusive** and **accountable governance processes** and mechanisms for water use, which influences food production;
- **increase** households' yields and turnover by providing innovative and adapted technologies and means, such as fertilizers and pesticides;
- **create** diversification of agricultural products at household level – for example, seedlings have been distributed to the rural population; and
- **reduce the level of poverty** in rural areas – the project has supported business initiatives, including agri-shops, greenhouses and community-based organizations.

[1] 2018 Global Nutrition Report. Bristol: Development initiatives; 2018 (https://globalnutritionreport.org/reports/global-nutrition-report-2018/, accessed 24 June 2019).
[2] Evans G, Wells N, Moch A. Housing and mental health: a review of the evidence and a methodological and conceptual critique. J Soc Issues. 2003;59(3):475–500. doi: http://dx.doi.org/10.1111/1540-4560.00074.
[3] Tajikistan: Food Security Monitoring Bulletin, Issue 19 (July 2017). Report from Department for International Development, World Food Programme, UN Children's Fund. New York: Reliefweb; 2017, 31 July (https://reliefweb.int/report/tajikistan/tajikistan-food-security-monitoring-bulletin-issue-19-july-2017, accessed 24 June 2019).
[4] Childhood stunting in Tajikistan: quantifying the association with WASH, food security, health, and care practices. report from the World Bank. New York: Reliefweb; 2018 (https://reliefweb.int/report/tajikistan/childhood-stunting-tajikistan-quantifying-association-wash-food-security-health, accessed 24 June 2019).

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. Following implementation of the intervention, many people took part in NRM training. For example: 21 groups from different villages participated in the development of NRM plans; 1951 people (including 1276 women) were trained on how to save water and how to enhance soil fertility to increase production. This resulted in better NRM.
2. More than 2000 people participated in practical agricultural training to increase food production. Following training, the gross yield increased by 35%, food security increased by 30% and food production for selling increased by 30%.
3. To ensure diversification of agricultural products, 8687 apple, apricots, poplar, dog-rose and other seedlings were distributed and planted. In addition, 10 729 apple, apricot, pear, walnut, almond and other tree seedlings were distributed to 38 agroforestry farmers and five demonstration plot owners for planting a total of 16.05 hectares of agroforestry plots.

Relevant HESRi[5] indicators

- Poverty
- Children developmentally on track
- Food insecurity
- Participation in training

Links to HESRi policy action areas

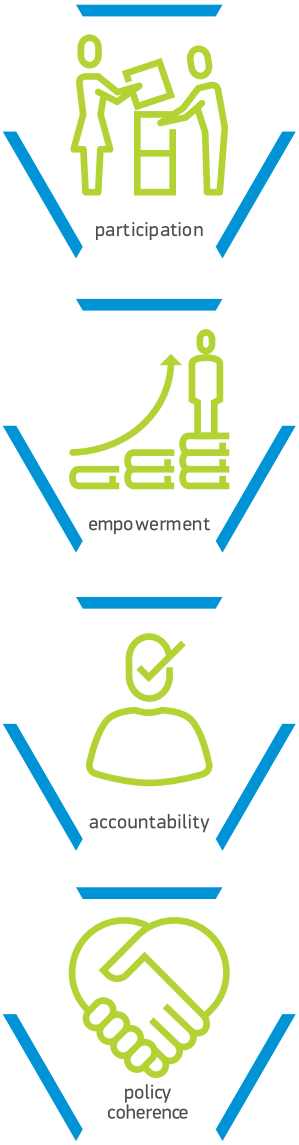
Living conditions

- Poverty is a significant driver of ill health and health inequity through its impacts on a wide range of health determinants, including food and nutrition security.
- Lack of proper nutrition, caused by not having enough food or eating poor-quality food (lacking the substances necessary for growth and health) leads to long-term cognitive impairment and hinders development.[1] Securing food (availability, accessibility, utilization and stability) and the livelihoods of current and future generations requires the responsible and sustainable use of natural resources.[6]

[5] The WHO European Health Equity Status Report Initiative.
[6] Environmental Policy, second draft. Rome: World Food Programme; 2016 (https://documents.wfp.org/stellent/groups/public/documents/resources/wfp288802.pdf, accessed 24 June 2019).

Links to HESRi Drivers

- The Sustainable Food and Nutrition Security project has implemented community-based NRM and a people-centred approach to the conservation of natural resources. This **empowers** local farmers and enhances the level of participation and engagement of local people.
- Providing local people with training on natural resource techniques and agricultural production **empowers** them and **fosters** the level of community engagement and trust.
- Having **supportive**, inclusive and **accountable** governance processes that involve farmers and local actors improve the accountability of the project.
- Inclusion of local actors and the Ministry of Health and Social Protection in the project's consortium increases the policy coherence of the project by **strengthening** an integrated response.



Further information

World Health Organization, United Nations Children's Fund, United States Agency for International Development. Improving nutrition outcomes with better water, sanitation and hygiene: practical solutions for policy and programmes. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/193991/9789241565103_eng.pdf?sequence=1, accessed 24 June 2019).

Environment and natural resource management. Resilient livelihoods through the sustainable use of natural assets. Rome: International Fund for Agricultural Development; 2015 (https://www.ifad.org/documents/38711624/39761608/enrm_e.pdf/dc466325-ba8d-4254-8c83-35e17fb62b88, accessed 24 June 2019).

Orientation framework: sustainable food and nutrition security. Bonn: Welthungerhilfe; 2015 (https://www.welthungerhilfe.org/news/publications/detail/orientation-framework-sustainable-food-and-nutrition-security/, accessed 24 June 2019).

2018 Global hunger index: forced migration and hunger. Report from Concern Worldwide, Welthungerhilfe. New York: Reliefweb; 2018 (https://reliefweb.int/report/world/2018-global-hunger-index-forced-migration-and-hunger, accessed 24 June 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Social and Human Capital

National Youth Strategy 2016–2025, North Macedonia

Description of the intervention

Education and employment are critical determinants of health inequity among young adults. In North Macedonia, a quarter of all young people do not participate in employment, education or training. In 2017 the unemployment rate for young people in the country was 47% and the school dropout rate was higher than the European Union average.

The National Youth Strategy 2016–2025 was developed with the aim to create the conditions to enable young people to fulfil their rights, needs and interests as active citizens and to improve their personal and professional development.[1] To inform the Strategy, a youth trend survey took place in 2014. The young people grouped the survey results into nine key areas: culture, education, employment and pre-employment support, health, local youth work, quality of life, sports, youth participation and youth information.

The Strategy's process is built on strong partnerships between multisectoral actors with different roles and responsibilities.

- The Government of North Macedonia is responsible for **implementing** and coordinating youth policies at the national level and also for monitoring implementation of the Strategy.
- Local authorities are responsible for planning local youth development programmes and for maintaining productive and constructive communication and cooperation between young people, as well as youth associations. This will **achieve** an inclusive and consultative process at the local level.
- Civil society organizations, including several associations and foundations, encourage and **influence** young people to participate in social activities and political debates on policies affecting their lives. Civil society organizations will have regular, continuous activities on topics that are selected jointly among the nine key areas of the Strategy.
- The business community contributes to the Strategy by making its economic resources available to tackle those needs identified in the survey at the national and local levels.
- Educational and health institutions are the key actors responsible for youth development.
- The media should connect young people with adults and raise awareness of the need for a **proactive** approach in promoting and implementing the Strategy.

Implementation of the Strategy is built on principles that are accepted and shared by all actors: equity, equality and inclusiveness, responsibility and accountability, cooperation and partnership, and professionalism.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The active participation of young people allows the National Youth Strategy to tackle issues that are important to this group and to translate key findings into actions.
2. The Strategy values the multicultural nature of North Macedonia and creates the conditions for all to play a role in implementing the Strategy.

Relevant HESRi[2] indicators

- Perceived ability to influence politics

[1] Republic of North Macedonia. 1.3 National youth strategy. In: EACEA National policies platform. Brussels: European Commission; 2019 (https://eacea.ec.europa.eu/national-policies/en/content/youthwiki/13-national-youth-strategy-former-yugoslav-republic-macedonia, accessed 26 March 2019).

[2] The WHO European Health Equity Status Report Initiative.

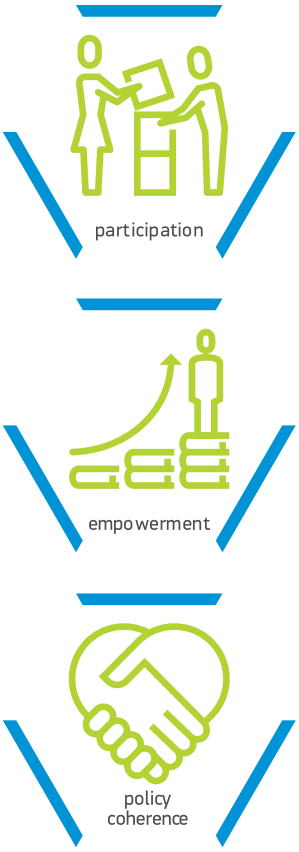
Links to HESRi policy action areas

Social and human capital

- Active participation of young people in society boosts/enhances societal change and diminishes their feelings of helplessness and social exclusion.
- The development of both formal and informal mechanisms of participation among young people increases awareness about their rights.

Links to HESRi Drivers

- Participation and social inclusion are at the core of the National Youth Strategy and encourage citizens to have a significant role in the social sphere, which increases their well-being.
- The Strategy empowers young people by increasing their political understanding and their participation in the decision-making process with both government and civil society organizations.
- The Strategy contributes to the removal of barriers, such as stigma and exclusion, by valuing the multicultural nature of North Macedonia.
- The Strategy strengthens policy coherence at the national level by sharing tasks and responsibilities among several actors.

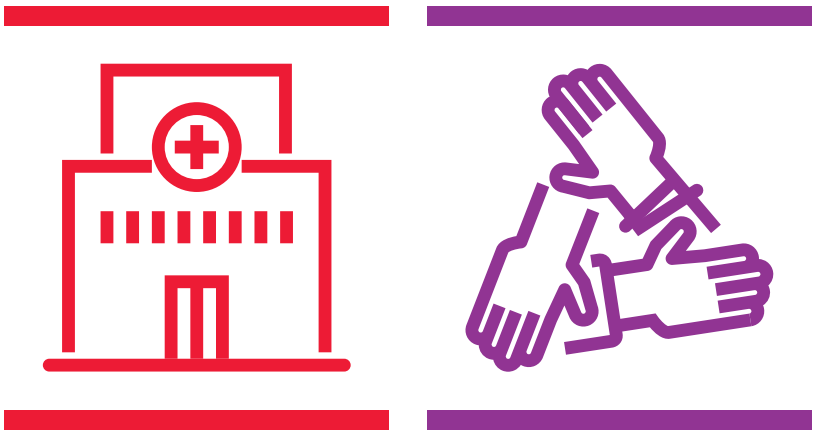


Further information

National youth strategy 2016–2025. Skopje: Youth and Sports Agency, Government of the Republic of Macedonia; 2016 (http://ams.gov.mk/images/dokumenti/mladi/National_Youth_Strategy_2016-2025_eng.pdf, accessed 25 March 2019).

Brown C, Harrison D, Burns H, Ziglio E. Governance for health equity: taking forward the equity values and goals of Health 2020 in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0020/235712/e96954.pdf, accessed 25 March 2019).

World Health Organization
REGIONAL OFFICE FOR Europe



Health & Health Services

Health & Social and Human Capital

Strengthening social cohesion between refugees and migrants and the host community in Turkey

Description of the intervention

When large groups of refugees and migrants arrive in a country, they can pose a challenge to national health systems and place unplanned pressure on the available capacities. An additional challenge to the increased demands on local services is addressing cultural and language barriers. Determinants of health, such as poor living conditions during transit and in destination countries, may worsen and negatively influence the level of health of refugees and migrants. The WHO Constitution defines health as "a state of physical, mental and social well-being and not merely the absence of disease or infirmity".[1]

Turkey has consistently provided significant support to many refugees seeking protection. It is estimated that more than 3.6 million Syrian refugees are hosted in the country and the total number of people under international protection is expected to be around 4 million.[2] If those with a residence permit are included in this calculation, then the number of migrants and refugees who need services without language and cultural barriers reaches almost 5 million. To respond to this complex crisis, WHO and the International Organization for Migration (IOM)[3] have focused on building country capacity in collaboration with national, regional and global partners. The aim is to deliver an effective operational response and to empower refugees and migrants in host communities to enhance inclusion and cohesion. As such, WHO and IOM have implemented several activities over many years that focus on refugees and migrants.

The WHO Country Office in Turkey supports the Turkish Government through the Refugee Health Programme and the Migration and Health Programme. These programmes respond to the overstretched capacities of the emergency services and aim to minimize the cultural and language barriers faced by refugees and migrants. The programmes also address the long-term health-system implications for refugees' and migrants' health and aims to **assist** in including their health matters into the national health-care system to improve the long-term outcomes.

The Turkish Ministry of Health has set up migrant health centres across the country to **strengthen** primary and secondary health-care services for Syrian refugees, who benefited from 600 000 free and culturally sensitive health consultations in 2018.[1] To support the Ministry of Health in improving the health system's response, WHO provides Syrian refugees who have medical training with further training courses with the aim of **integrating** them into the Turkish health system. The training consists of:

- a one-week theoretical course; and
- six weeks of on-the-job training, in which Syrian doctors and nurses provide health-care services for refugees in WHO-supported health centres across the country.

Once the training is complete, Syrian refugees with a medical background are employed by the Turkish Ministry of Health in health centres, where they contribute to national health systems and have advanced knowledge of national programmes, strategies and policies. They are responsible for conducting culturally sensitive health consultations and for strengthening access to quality health services (including protective and preventive primary health-care services) and ensuring treatment continuation and vaccination.

To tackle and reduce the cultural and language barriers, WHO also provides training that includes:

- courses on medical terminology and concepts related to a variety of public health topics, such as mental health and psychosocial support for Arabic/Turkish interpreters/patient guides who assist patients in local health clinics and hospitals; and
- specialized courses on mental health-care services for Turkish and Syrian health-care workers, to support interventions in a broad range of issues, from the quality of care provided to the psychosocial assistance required to address mental health needs in early childhood.

IOM's programmes support refugees and migrants by providing psychosocial support services in rural areas and small districts, which are more likely to have limited access to health services and education.

[1] Basic document, 48th edition. Geneva: World Health organization; 2014 (http://apps.who.int/gb/bd/PDF/bd48/basic-documents-48th-edition-en.pdf#page=1, accessed 28 June 2019).

[2] Syria regional refugee response. In: Operational portal: refugee situations [website]. Office of the United Nations High Commissioner for Refugees; 2019 (https://data2.unhcr.org/en/situations/syria, accessed 28 June 2019).

[3] The IOM intervention is in line with the objectives of the *Global Compact for Safe, Orderly and Regular Migration*; paragraph 15: Provide access to basic services for migrants; paragraph 16: Empower migrants and societies to realize full inclusion and social cohesion); and to Objective 2 of the IOM Migration Governance Framework (Effectively address the mobility dimensions of crises). Global compact for safe, orderly and regular migration. Geneva: International Organization for Migration; 2018 (https://refugeesmigrants.un.org/sites/default/files/180713_agreed_outcome_global_compact_for_migration.pdf, accessed 28 June 2019). Migration governance framework. Geneva: International Organization for Migration; 2015 (https://www.iom.int/sites/default/files/about-iom/migof_brochure_a4_en.pdf, accessed 28 June 2019).

Specialized mobile IOM teams composed of social workers, psychologist and animators visit migrants and refugees in these areas on a weekly basis to:

- organize discussions on current main issues to engage them
- run activities including psychoeducation
- **increase awareness** on several topics including legal rights and referrals to state services
- run activities to **increase** health promotion (e.g. reproductive health).

IOM is also collaborating with local municipalities to support and deliver better services. This aspect of the project aims to create an integrated service delivery to refugees and migrants to:

- **facilitate access** to basic services;
- **promote** and **enhance** social cohesion with the host community; and
- **improve** health literacy through health promotion activities on reproductive health, hygiene and nutrition.

WHO and IOM interventions have contributed to improving the physical and mental health and well-being of refugees and migrants. These interventions have reduced language and cultural barriers between refugees and migrants and the host community and strengthened the capacities of Turkish health systems.

The services provided are a good example of the Sustainable Development Goal approach to leave no one behind and represent a step towards achieving universal health coverage.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. In 2018 the WHO programme achieved very positive results[4]: 700 Syrian doctors, nurses and midwives completed the adaptation training to serve in the Turkish health-care system. Having Turkish and Syrian health workers practising together in health centres enhances social cohesion and improves the health system's capacity.
2. In 2018 IOM's mobile teams reached 17 245 individuals through psychosocial support sessions, information sessions and social cohesion activities.
3. To reduce cultural and language barriers, more than 700 Arabic and Turkish interpreters attended WHO training courses to serve as patient guides for Syrian Refugees.
4. To support the mental health needs of refugees, approximately 150 Turkish and Syrian doctors received specialized training in mental health and psychosocial support.
5. The IOM project increased access to health services for almost 20 000 refugees and migrants.
6. Strong alliances and common approaches among the local and international actors have been helpful for better identifying gaps and coordinating resources.

Relevant HESRi[5] indicators

- Avoidable hospital admissions
- Self-reported unmet needs for health care
- Vaccination coverage in children
- Trust in others

Links to HESRi policy action areas

Health services

- Health-related vulnerabilities can increase owing to lack of access to health services, poor nutrition, and inadequate hygiene and sanitation caused by the poor housing that tends to be available for migrants and refugees arriving in a host country.

[4] Photo story – the human impact of WHO's Refugee Health Programme in Turkey. In: Syria crisis: health response from Turkey [website]. Copenhagen: WHO Regional Office for Europe; 2019 (http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/multimedia/photo-story-the-human-impact-of-whos-refugee-health-programme-in-turkey, accessed 28 June 2019).

[5] The WHO European Health Equity Status Report Initiative.

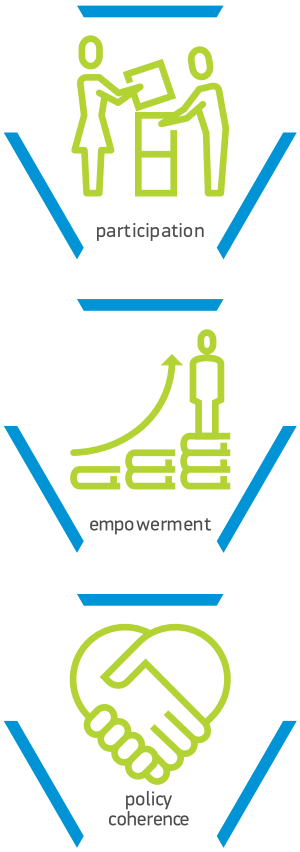
- Mental health needs among refugees are high owing to their experiences of violence, anxiety and post-traumatic stress disorder. Mitigating the negative effects of the conflict improves refugees' health and well-being.
- Refugees and migrants may be excluded from accessing primary health-care services and health promotion interventions because of their legal status, language and cultural barriers, and their low income-levels.

Social and human capital

- By setting up migrant and refugee health centres, stigma, discrimination and cultural barriers may decrease and access for refugees to public services may improve.
- Providing comprehensive and quality primary health-care services significantly reduces strains in other service points, thereby preventing possible tensions and contributing to social cohesion.
- Tailored interventions to increase health literacy in various aspects of refugee and migrant health could improve health outcomes through lowering the rates of hospitalization and increasing the use of preventive services.
- Providing refugees and migrants with training and employment opportunities to support the work of health centres can **promote** the creation of inclusive public services and improve social cohesion.
- Creating a space for discussion between the host community and refugees and migrants **promotes** the creation of inclusive social environments, which improves social cohesion.
- Developing culturally sensitive and competent health services, as well as participatory programmes for both refugees and the local community, **enhances** integration and participation.

Links to HESRi Drivers

- Collaboration between refugees and the host community **strengthens** social cohesion and increases resilience among the refugee community, medical professionals themselves and the overall health system.
- A community-based approach ensures the promotion of psychosocial well-being and reduces conflicts between refugees and migrants and their host community. This **increases** migrants' and refugees' resilience and empowerment.
- The initiatives aim to improve the health of elderly refugees and migrants and those with disabilities, and to increase their health literacy and knowledge of legal rights, thus increasing their integration into the community and the level of control over their lives.
- By working closely with the Ministry of Health, the interventions created a strong partnership and strengthened the framework for a comprehensive response to the current situation. This resulted in strong policy coherence among the programmes, which gave additional donors the confidence to provide further support.



Further information

Turning a refugee health challenge into an opportunity in Turkey. Inaugural WHO Partners Forum case study. Geneva: World Health Organization; 2019 (https://www.who.int/docs/default-source/un-high-level-meeting-on-tb/3-syrian-refugee-programme-in-turkey.pdf?sfvrsn=fe7f0252_2, accessed 28 June 2019).

Schinina G, Tankink M. Introduction to special section on: psychosocial support, conflict transformation and creative approaches in response to the needs of Syrian refugees in Turkey. Intervention. 2018;16(2):161–3. doi: 10.4103/INTV.INTV_36_18.

Together in the EU. Promoting the participation of migrants and their descendants. Vienna: European Union Agency for Fundamental Rights; 2017 (https://fra.europa.eu/sites/default/files/fra_uploads/fra-2017-together-in-the-eu_en.pdf, accessed 28 June 2019).

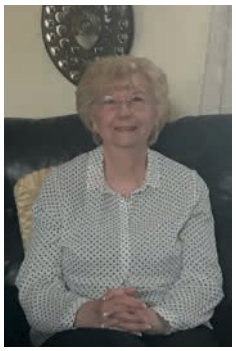
IOM appeal 2019. Syria crisis: humanitarian response plan – regional refugee and resilience plan. Geneva: International Organization for Migration; 2019 (https://www.iom.int/sites/default/files/country_appeal/file/syria_ap_syria_crisis_2019.pdf, accessed 28 June 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Living Conditions

Arbed and Nest schemes as part of the Welsh Government's Warm Homes Programme

Description of the intervention



Living in cold homes and in fuel poverty (when more than 10% of a household's income is spent on energy costs) contributes to poor physical and mental health. People who struggle to heat their homes are usually in low-income households. Estimates show that approximately 291 000 households in Wales (United Kingdom) are living in fuel poverty – equivalent to 23% of households.

In the Welsh Government Warm Homes Programme, local authorities and communities, small and medium-sized enterprises, and civil society organizations play a key role in identifying opportunities to provide community benefits and ensuring their delivery.

The **Arbed** and **Nest** schemes are part of the Warm Homes Programme, which was developed by the Welsh Government to:

- help eradicate fuel poverty
- **reduce** carbon emissions
- **accelerate** economic development and regeneration in Wales.

Both schemes adopt a whole-house approach to home energy efficiency improvements to tackle fuel poverty. Although they have the same goal, the schemes are implemented in different ways.

To benefit from the Arbed scheme, households need to:

1. take part in a survey to assess the energy performance of the property, and receive an offer of assistance
2. if selected, book a technical survey with an appointed installer to prepare the works
3. arrange a final quality inspection to check the newly installed system.

To access the Nest scheme, households are expected to answer questions to assess their eligibility for free home energy efficiency improvements.

- If eligible, they can obtain a free package of energy efficiency measures, such as a new gas boiler, central heating system and/or insulation.
- If ineligible, they receive free advice on saving energy, money management and energy tariffs.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The Warm Homes Programme has made energy efficiency improvements to more than 50 800 homes (mainly of people on low incomes or in the most deprived areas of Wales) and energy advice to over 113 000 households.
2. To improve home energy efficiency, the Welsh Government Warm Homes Programme engages with local supply chains, resulting in new jobs for local communities.
3. By improving the energy efficiency of a property, the Nest and Arbed schemes make householders more resilient to future energy price rises.

Relevant HESRi[1] indicators

- Inability to adequately heat the home
- Annual mean PM10[2] concentrations

[1] The WHO European Health Equity Status Report Initiative.
[2] Particulate matter of 10 µm or less in diameter.

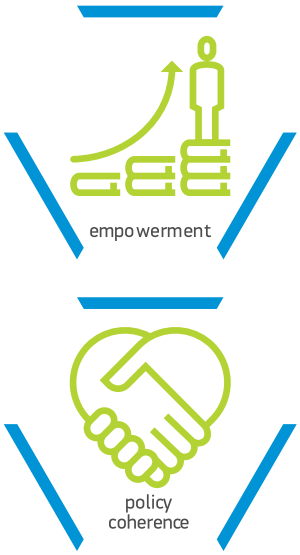
Links to HESRi policy action areas

Living conditions

- People in low-income households on often live in deprived areas with poor-quality housing that is expensive to heat.
- Cold homes and fuel poverty lead to health and social inequities, which disproportionately affect elderly people, infants, and people with disability and long-term illness.
- Fuel poverty may negatively affect health, by reducing indoor temperatures, and mental well-being, through associated social problems such as social isolation and increased stress from making financial trade-offs, such as having to choose whether to heat or eat.
- The installation of new energy systems has positive health effects through providing a health-enabling environment, tackling gas emissions reduction and reducing the risk of respiratory diseases, lung cancer and cardiovascular disease.

Links to HESRi Drivers

- Involvement of the local community increases the levels of awareness, resulting in a more joined-up approach which motivates local citizens to find solutions to improving their health level and living conditions.
- Arbed and Nest schemes are aligned with the well-being goals and sustainable development principles of the Well-being of Future Generations (Wales) Act 2015,[3] which requires public bodies and the Welsh Government to **collaborate** with communities to take a more incorporated approach to health and well-being.



[3] Well-being of future generations (Wales) act 2015: the essentials. Cardiff: Welsh Government; 2015 (https://gov.wales/docs/dsjlg/publications/150623-guide-to-the-fg-act-en.pdf, accessed 10 March 2019).

Further information

Nest annual report 2017–2018. Cardiff: Welsh Government; 2018 (https://nest.gov.wales/workspace/uploads/files/nest-report_2017-18_english_fi-5b4c9a0604a6c.pdf, accessed 9 March 2019).

Grey C, Jiang S, Nascimento C, Rodgers SE, Johnson R, Lyons RA et al. The short-term health and psychosocial impacts of domestic energy efficiency investments in low-income areas: a controlled before and after study. BMC Public Health. 2017;17(1):140. doi: 10.1186/s12889-017-4075-4.

Grey CNB, Schmieder-Gaite T, Jiang S, Nascimento C, Poortinga W. Cold homes, fuel poverty and energy efficiency improvements: A longitudinal focus group approach. Indoor Built Environ. 2017;26(7):902–13. doi: 10.1177/1420326X17703450.

Ambient air pollution: a global assessment of exposure and burden of disease. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/bitstream/handle/10665/250141/9789241511353-eng.pdf?sequence=1, accessed 9 March 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Social and Human Capital

The Wales We Want: empowering citizens to own and drive equity policy solutions

Description of the intervention

Great inequities persist within countries owing to complex determinants such as income, geographical location, culture and lifestyles. Those inequities negatively impact on the levels of health and well-being of individuals.

In Wales (United Kingdom) people from different socioeconomic backgrounds have different life expectancies and healthy life expectancies owing to diverse health outcomes. The difference in life expectancy between men with the highest socioeconomic status and those with the lowest socioeconomic status is nine years. For women, the difference is seven years. The respective differences in healthy life expectancy are substantially greater, at 19 years for men and 18 years for women.

To address these differences, the Well-Being of Future Generations Act commits the Welsh Government and all public bodies in Wales to take collective action to deliver a prosperous, resilient, healthier, more equal and globally responsible Wales, along with a vibrant culture and a thriving Welsh language.

To shape the Act, a National Conversation was held to identify the issues to be tackled to achieve "The Wales We Want". In this process communities had a central role in **driving change** rather than being subject to it, and in designing jointly owned policy solutions.

The National Conversation:

- engaged nearly 7000 people across Wales through their communities and groups, social media, and online platforms;
- recruited Futures Champions to take the conversation forward, advocate for future generations and raise issues affecting their groups, communities and organizations; and
- gave citizens the chance to adapt "The Wales We Want" to their own interests, resulting in "The Town We Want", "The Wales Women Want", "The Wales Carers Want", "The Energy We Want" and "The Wales Young People Want" – each adapted conversation helped to build a common set of values, which has been used to identify measurable outcomes of the Act.

To ensure the involvement of the broader community and support the strategy:

1. Local Public Service Boards, involving all public sectors bodies, were established to engage the community they serve in securing local improvements; and
2. a Future Generations Commissioner for Wales was appointed to act as a guardian of the ability of future generations to meet their needs, and to support public bodies to meet their obligations and duties.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. Conversations across Wales highlighted important issues, such as climate change, poverty and health inequalities, and increased awareness about these topics. By increasing knowledge, the community is more likely to feel empowered and to tackle the issues that matter to them. Participating in conversations such as "The Wales Women Want" or "The Wales Carers Want" increases people's sense of belonging and aims to improve their confidence to help them contribute to social changes.
2. The National Conversation **strengthened** engagement between communities and decision-makers.
3. The Future Generations Commissioner and Local Public Service Boards encourage public bodies to meet their responsibilities and to take greater account of the long-term impact of their actions.

Relevant HESRi[1] indicators

- Perceived ability to influence politics

[1] The WHO European Health Equity Status Report Initiative.

Links to HESRi policy action areas

Social and human capital

- The National Conversation gave everyone the chance to inform the Well-Being of Future Generations Act. The central role of communities in **driving change** positively impacts their perceived level of **influence** and diminishes their perceived level of helplessness.
- Designing jointly owned solutions contributes to building individual and community self-efficacy and resilience.

Links to HESRi Drivers

- The National Conversation empowered the community by improving engagement at local level and by influencing the health and well-being of individuals who participate in decisions affecting their daily life.
- Empowerment creates resilience and a greater sense of responsibility by enabling communities to do things for themselves.
- Creating a sociopolitical environment in which citizens are motivated to seek meaningful solutions to common problems and examine opportunities of various policy options improves community cohesion and reciprocal trust.
- The National Conversation was a transparent and inclusive process that aimed to foster democratic processes and contribute to a better-informed political debate.
- The Well-Being of Future Generations Act is an opportunity to **make progress** towards a Health in All Policies approach and to think about all policies in health, for example by focusing on how healthier individuals can contribute to strengthening the economy, thereby making communities more resilient.

Further information

Rebalancing healthcare: working in partnership to reduce social inequity. Chief Medical Officer for Wales Annual Report 2015-16. Cardiff: Welsh Government; 2016 (https://gov.wales/docs/dhss/publications/161110cmoreport16en.pdf, accessed 5 April 2019).

Well-being of Future Generations (Wales) Act 2015. Cardiff: Welsh Government; 2016, 8 August (https://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en, accessed 5 April 2019).

Community well-being profile. Final. Newport, Wales: One Newport; 2017 (http://www.newport.gov.uk/documents/One-Newport/Community-Well-being-Profile-Final-2017.pdf, accessed 5 April 2019).

The Wales we want report: a report on behalf of future generations. Cardiff: Welsh Government; 2015 (http://bailey.persona-pi.com/Public-Inquiries/A465-English/7%20-%20Sustainability/7.3.9%20-%20The%20Wales%20We%20Want%20Report%20ENG%202010.pdf, accessed 5 April 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Social and Human Capital

Cross-Party Group on Health Inequalities, Scotland (United Kingdom)

Description of the intervention

Health inequities are the unjust and avoidable differences in people's health across the population and between specific population groups. They are socially determined by circumstances that are largely beyond an individual's control and which disadvantage people and limit their chance to live longer, healthier lives.

To tackle health inequalities, the Scottish Parliament Cross-Party Group on Health Inequalities was established at the start of the 2012–2016 Scottish parliamentary session in order to raise awareness and promote action.

The official aim of the Group is to raise awareness of the causes of health inequalities among:

- parliamentarians, who can influence legislation; and
- policy-makers, to promote evidence-based actions to reduce health inequalities and avoid legislation and policies that will worsen health inequalities in Scotland.

The Group has three co-convenors, who are all Members of the Scottish Parliament (MSPs). The Group's Secretariat is Voluntary Health Scotland, a nongovernmental, civil society body. The Group provides an opportunity for MSPs of all political parties, external organizations and invited individuals (e.g. academics) to meet and discuss their shared concerns about health inequalities.

The Group has a broad membership, comprising 10 MSPs and 73 members of public and civil society organizations, and invited experts. It meets up to five times a year to discuss topics related to health inequalities and holds an annual Parliamentary Event to promote its work.

The Group works to:

- build stronger links and engagement between politicians, policy-makers, the public and third sectors, academia, the private sector. and civil society;
- take **actions** on the least-understood and less well-examined areas of health inequalities;
- **accelerate** cross-sectoral actions and collaboration;
- gather evidence, ideas and views; and
- focus on how specific issues and partners could and should contribute to addressing Scotland's health inequalities.

Although the Group is entirely independent of the Scottish Government, its work aligns with a number of ongoing and new policy initiatives, including:

- the National Performance Framework for Scotland, which is centred on 16 National Outcomes including health, poverty, communities, fair work, human rights, children and young people, environment, education, and culture;
- the Public Health Reform programme, which aims to establish a new strategic body, Public Health Scotland, to coordinate and drive efforts on health inequalities; and
- six national public health priorities, which are designed to accelerate progress in tackling health inequalities by providing a national focus and fostering collaboration between the Scottish Government, National Health Service boards, local authorities, community planning partnerships and civil society organizations.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The Cross-Party Group on Health Inequalities joins together knowledge and learning and focuses on identifying innovative solutions.
2. The Group's multisectoral nature contributes to making health inequalities relevant for all ministries and sectors, thereby helping to address factors outside of the health system that are related to the determinants of health.
3. Thanks to the its broad representation, the Group boosts action and better engages with local citizens in tackling health inequalities.

Relevant HESRi[1] indicators

- Perceived ability to influence politics

Links to HESRi policy action areas

Social and human capital

- Political participation promotes inclusion by increasing people's perception of their ability to influence decisions.
- Involving the broader society in discussions concerning health promotes equitable access to health-promoting goods and alleviates the unequal distribution of power and resources.

Links to HESRi Drivers

- The Cross-Party Group on Health Inequalities takes the Equity in All Policies Approach, which strengthens policy coherence across sectors and among stakeholders.
- By empowering local people, solutions can be identified and established from the inside, while enhancing a participatory approach.
- This approach not only improves social inclusion but also enhances collaboration in the policy-development process.
- The Group seeks to examine and inform debate in the Scottish Parliament; legislation; and Scottish Government policy to support broad and coherent actions towards creating conditions for equitable health and well-being. The Group has discussed relevant Scottish Government policy areas including health and social care integration; health and social care standards; mental health; housing and the environment; fuel poverty; loneliness and social isolation; and culture.

[1] The WHO European Health Equity Status Report Initiative.

Further information

Long-term monitoring of health inequalities: December 2018 report. Edinburgh: Directorate for Finance, eHealth and Analytics, Scottish Government; 2018 (https://www.gov.scot/publications/long-term-monitoring-health-inequalities-december-2018-report/, accessed 28 February 2019).

University College London Institute of Health Equity. Review of social determinants and the health divide in the WHO European Region: final report. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0004/251878/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-FINAL-REPORT.pdf, accessed 28 February 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Living Conditions

Modelling the impact of minimum price for alcohol in Scotland (United Kingdom)

Description of the intervention

Alcohol is central to a range of health inequalities. In general, people in lower socioeconomic groups consume less alcohol overall and those who do drink consume less on average than higher-income drinkers. However, lower socioeconomic groups experience higher levels of alcohol-related harm compared with wealthier groups with the same level of alcohol consumption. Evidence has shown that the heaviest drinkers from lower economic backgrounds are more likely to binge drink and to consume large amounts of cheap, strong alcohol. In addition, because of exposure to greater levels of life stressors (e.g. financial instability) or to higher prevalence of other unhealthy behaviours (e.g. inadequate nutrition), those people are more likely to experience problematic and harmful consequences compared with people with higher income.

Increasing the price of alcohol has a strong influence in reducing harmful alcohol consumption, and those from lower socioeconomic backgrounds are more likely to reduce their consumption with increases in price.[1] Increasing prices can reduce the demand among those who buy cheap, strong alcohol, without having highly regressive effects: as the heaviest drinkers from lower-income groups are more sensitive to pricing, they will reduce their alcohol use to a greater extent than higher-income persons. One such price-related policy is **minimum unit pricing** (MUP), which sets a price level below which retailers are not allowed to sell alcohol.

In 2012 the Scottish Government launched a strategic approach to tackle alcohol consumption and proposed MUP as a method to improve public health.

MUP was proposed as it has the potential to **impact** on those who are:

- more likely to drink cheap, strong alcohol
- disproportionately affected by alcohol-related morbidity and mortality.

The Alcohol (Minimum Pricing) (Scotland) Act 2012 specified that alcohol could not be sold below the price of 50p per 10 ml pure alcohol (a United Kingdom unit). The aim was to reduce alcohol-related harm.

Initially, the modelling work appraised the impact of MUP of 30p, 40p, 50p, 60p and 70p per 10 ml pure alcohol and, consequently, of a taxation (alcohol duty) intervention.

MUP has an impact on hazardous and harmful drinkers who tend to favour cheap, strong alcohol. To gather different views on MUP and see changes in alcohol-related harms and consumption, a range of interested parties have participated in consultations and surveys. These include:

- people using alcohol
- young people under the age of 18 years
- alcohol treatment services
- public health bodies
- alcohol industry organizations and business.

Following nearly six years of legal challenges by the alcohol industry, courts including the European Court of Justice and the United Kingdom Supreme Court found a MUP of 50p to be a proportionate response to tackling alcohol-related harm in Scotland. The Scottish Government introduced a 50p MUP on 1 May 2018.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The modelling work estimates the impact of MUP on different socioeconomic groups. For a 50p MUP, the research found that alcohol consumption would be reduced by 3.5% on average: the reduction would be 7% for harmful drinkers, 2.5% for hazardous drinkers and 1.2% for moderate drinkers.

[1] Wood S, Bellis M. Socio-economic inequalities in alcohol consumption and harm: evidence for effective interventions and policy across EU countries. Brussels: European Union; 2017 (https://ec.europa.eu/health/sites/health/files/social_determinants/docs/hepp_screport_alcohol_en.pdf, accessed 16 April 2019).

2. The reduction in the number of deaths is estimated to be largest among harmful drinkers living in poverty, with 15.3% fewer alcohol-related deaths per year compared with 4.4% fewer among harmful drinkers not in poverty. The equivalent reduction for hazardous drinkers is 10.8% for those in poverty and 4.4% for those not in poverty.
3. An estimated 28% increase in tax (alcohol duty) would be required to achieve the same reduction in the number of deaths among hazardous and harmful drinkers as a MUP of 50p.

Relevant HESRi[2] indicators

- Value added tax on alcohol
- Alcohol consumption
- Alcohol consumption (risky single-occasion drinking)

Links to HESRi policy action areas

Living conditions

- In European countries alcohol is a leading risk factor for diseases, including several cancers, cardiovascular disease, liver disease and mental health conditions.
- Those living in lower-income environments are more likely to experience problematic drinking[3] because of poorer access to support and pre-existing problems (e.g. financial instability).

Links to HESRi Drivers

- MUP relies on the Health in All Policies approach, with several stakeholders and ministries **supporting** this strategic approach. They will decide whether to continue MUP after considering the impact of the intervention.
- This strategic approach **enhances** social participation by giving people the chance to participate in public consultation regarding the introduction of MUP.
- Public consultations and surveys increase awareness and produce new collective knowledge on alcohol, which impacts on people's health and well-being.

[2] The WHO European Health Equity Status Report Initiative.
[3] Loring B. Alcohol and inequities: guidance for addressing inequities in alcohol-related harm. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0003/247629/Alcohol-and-Inequities.pdf?ua=1, accessed 16 April 2019).

Further information

Angus C, Holmes J, Pryce R, Meier P, Brennan A. Model-based appraisal of the comparative impact of Minimum Unit Pricing and taxation policies in Scotland: An adaptation of the Sheffield Alcohol Policy Model version 3. Sheffield: University of Sheffield; 2016 (https://www.sheffield.ac.uk/polopoly_fs/1.565373!/file/Scotland_report_2016.pdf, accessed 16 April 2019).

Bellis M. Wood S. Health equity pilot project (HEPP): modelling the impact of minimum unit price for alcohol. Brussels: European Commission; 2017 (https://ec.europa.eu/health/sites/health/files/social_determinants/docs/hepp_case-studies_06_en.pdf, accessed 16 April 2019).

Minimum unit pricing (MUP) evaluation summary. Edinburgh: NHS Health Scotland; 2018 (http://www.healthscotland.scot/media/1807/minimum-unit-pricing-mup-evaluation-summary.pdf, accessed 16 April 2019).

Meier P. Brennan A. Angus C. Holmes C. Editorial. Minimum unit pricing for alcohol clears final legal hurdle in Scotland. BMJ. 2017;359:j5372. doi: https://doi.org/10.1136/bmj.j5372.

Alcohol in the European Union. Consumption, harm and policy approaches. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/en/publications/abstracts/alcohol-in-the-european-union.-consumption,-harm-and-policy-approaches, accessed 16 April 2019).

Smith K, Foster J. Alcohol, health inequalities and the harm paradox: why some groups face greater problems despite consuming less alcohol. London: Institute of Alcohol Studies; 2016 (http://www.ias.org.uk/uploads/pdf/IAS%20reports/IAS%20report%20Alcohol%20and%20health%20inequalities%20FULL.pdf, accessed 16 April 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Living Conditions

Health & Social and Human Capital

Co-producing policy and research with older people in Manchester, England (United Kingdom)

Description of the intervention

By 2030 a quarter of the urban population in Europe is expected to be aged over 60 years.[1] Many older people feel cut off from society and unable to gain equal opportunities in their community due to, for example, lack of security and support and difficulties in accessing public transport and services. As a result, they spend most of their time at home or in the immediate environment, which thus limits their full participation in the community and impacts their health and well-being.

As part of a research project in three low-income neighbourhoods in south Manchester, England (United Kingdom), older residents were recruited as co-researchers, working alongside academics, community organizations and policy-makers.[2] The research project aimed to improve the age-friendliness of their neighbourhood. As co-researchers, older residents were provided with training sessions about the different components of the research process. The co-researchers took part in:

- designing the research materials, which needed to be sensitive to the needs of older people, whose voices are not usually heard;
- implementing the research: to this end, the 18 co-researchers conducted 68 qualitative interviews with socially isolated older people living in low-income neighbourhoods in Manchester – interviewees were asked to speak about the main issues they face in the urban community;
- analysing the research findings to identify common issues faced by older people in their daily lives; and
- disseminating findings with community stakeholders, including voluntary organizations, care groups and health services.

The inclusive nature of the research project provided a more detailed insight of the problems of older residents and made it easier to identify key priority areas for local government, such as improving local transport, making pavements more accessible, and regenerating public spaces.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. The project is built on a partnership between Manchester City Council, the University of Manchester and a range of partners including local government, voluntary organizations, nongovernmental organizations and the health sector, which **influences** and contributes to re-thinking public policy in relation to age-friendly cities.
2. The direct involvement of older people in the project has improved the age-friendliness of neighbourhoods, thereby contributing to a better quality of life in disadvantaged areas.
3. By engaging groups that are usually left behind, it is easier to identify real needs and ensure that the city's resources are used more effectively towards the needs of everyone.
4. The project's findings have resulted in tangible changes in the city. For instance, older co-researchers played a key role in campaigning for the successful restoration of a bus service.

Relevant HESRi[3] indicators

- Public transport
- Green space
- Community amenities
- Perceived ability to influence politics

[1] World population ageing 2015. New York: Department of Economic and Social Affairs, Population Division, United Nations; 2015 (http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf, accessed 28 February 2019).
[2] Researching age-friendly neighbourhoods. In: Sociology [website]. Manchester: University of Manchester; 2019 (https://www.socialsciences.manchester.ac.uk/sociology/research/impact/age-friendly-neighbourhoods/, accessed 13 March 2019).
[3] The WHO European Health Equity Status Report Initiative.

Links to HESRi policy action areas

Living conditions

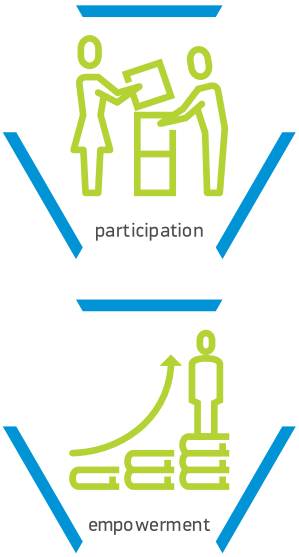
- Healthy transport modalities are essential for accessing services and represent a critical issue in health equity and to mitigate inequities in social isolation, mental health, and well-being.
- Access to good quality urban environments has a major impact on health and well-being, especially in less wealthy neighbourhoods.
- Age-friendly environments permit older people to **maximize** their abilities and capacities, participate in social activities, and access public services and facilities.

Social and human capital

- Being able to participate in community life, make decisions, keep learning and make choices have a positive impact on older people's mental and physical health, identity and sense of control.
- Giving those who are left behind the chance to make decisions about their community and their living environment creates a more equitable society, in which everyone can raise their voice. Improving lower-income neighbourhoods and transportation links enhances communal trust, improves social capital and the development of civic and civil society.

Links to HESRi Drivers

- The project gives older people the chance to **actively participate** in the community by identifying real needs and solutions to improve the quality of their urban environment, resulting in increased control over their destiny, which affects their health status and is a key driver of health equity.
- The project promotes social participation by laying the foundations for active ageing which promotes **active participation** in all aspects of social, economic, cultural and civic life, and has an impact on older people's health and well-being.
- By taking part in the project, the increased awareness of older residents of their internal capacity for action, enabled them to (i) exercise their power to **influence** decisions that impact their lives and (ii) diminish their sense of powerlessness, a chronic stressor that leads to depression and anxiety.



Further information

Buffel T. Social research and co-production with older people: developing age-friendly communities. J Aging Stud. 2018;44:52–60. doi: 10.1016/j.jaging.2018.01.012.

Buffel T. Older coresearchers exploring age-friendly communities: an "insider" perspective on the benefits and challenges of peer-research. Gerontologist. 17;59(3):538–48. doi: 10.1093/geront/gnx216.

World report on ageing and health. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf?sequence=1, accessed 28 February 2019).

Social Exclusion Unit. Making the connections: final report on transport and social exclusion. London: Social Exclusion Unit; 2003 (http://www.ilo.org/wcmsp5/groups/public/---ed_emp/---emp_policy/---invest/documents/publication/wcms_asist_8210.pdf, accessed 28 February 2019).

Peppin Vaughan R. Education for people and planet: creating sustainable futures for all. Gender equality and education in the Sustainable Development Goals. Paris: United Nations Educational, Scientific and Cultural Organization; 2016 (ED/GEMR/MRT/2016/P1/7 Rev; http://unesdoc.unesco.org/images/0024/002455/245574E.pdf, accessed 28 February 2019).

Boyce T, Brown C. Engagement and participation for health equity. Copenhagen: WHO Regional Office for Europe; 2017 (http://www.euro.who.int/__data/assets/pdf_file/0005/353066/Engagement-and-Participation-HealthEquity.pdf?ua=1, accessed 28 February 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Social and Human Capital

TOY for Inclusion: toys to share, play to care

Description of the intervention

As Europe's most disadvantaged population, Roma experience social exclusion and unequal treatment in accessing health, education, employment, housing and other services. This form of discrimination has a particular impact on children by preventing them from accessing high-quality education and having a safe, healthy childhood.

The Initiative Together Old and Youth (TOY)[1] has been implemented by the International Child Development Initiatives. It addresses issues such as segregation and discrimination, which Roma children experience from a very early age.

The aim is to improve the experience of those children in transitioning from home to preschool by combining two approaches:

1. intergenerational learning opportunities between older adults and young children
2. community-based early childhood education and care (ECEC).

TOY for Inclusion has set up community-based ECEC Play Hubs in Belgium, Croatia, Hungary, Italy, Latvia, Slovakia and Slovenia.

Play Hubs are located in areas accessible to both Roma and non-Roma families so that children and their families can take part in community-based integrated services. They are run by local committees made up of local action teams, with representatives from school and preschool teachers, community development workers, civil society, health professionals and other local stakeholders and authorities.

Local action teams:

- help children to develop the necessary competences and knowledge for formal education
- **mobilize** local communities around young children
- organize intergenerational activities involving older people with and without a Roma background.

TOY for Inclusion promotes diversity, equity and inclusion, relies on a whole-family approach and increases equity in access to high-quality ECEC services.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. During the first period of implementation (2018), over 3000 children (approximately 25% of whom were Roma) participated in activities in the Play Hubs and almost 2000 parents and grandparents took part in activities with practitioners.
2. Play Hubs are useful in bringing Roma and non-Roma communities together, building parenting skills, and **improving** cooperation between the civil society and local agencies.
3. Across Europe, Play Hubs are making the transition from ECEC to primary school easier for Roma children, improving children's knowledge and competencies, and increasing Roma communities' trust in local services.
4. The involvement of health professionals in local action teams promotes the concept of service integration at local level.

[1] Toy for inclusion [website]. Leiden: Romani Early Years Network; 2019 (www.toy4inclusion.eu, accessed 10 March 2019).

Relevant HESRi[2] indicators

- Participation in early childhood education
- Public spending on housing and community amenities
- Trust in others

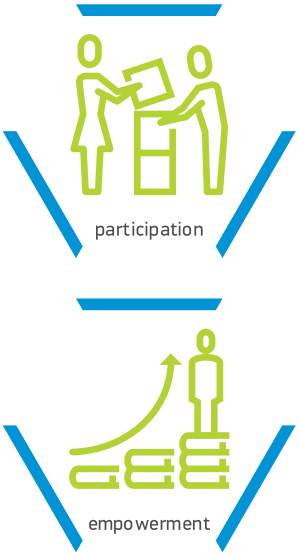
Links to HESRi policy action areas

Social and human capital

- High-quality ECEC influences social and cognitive development. Years of international research have shown that those who have been given high-quality ECEC are less likely to experience future unemployment, commit crimes or participate in antisocial behaviour.
- ECEC Play Hubs provide safe spaces and reach those left behind, who often have problems accessing health and social services.
- Community development initiatives target additional resources to disadvantaged neighbourhoods by improving social capital, which is generally lower in socioeconomically disadvantaged areas.

Links to HESRi Drivers

- TOY for Inclusion adopts an intergenerational learning approach, which helps to decrease the marginalization of young and older people.
- TOY for Inclusion **facilitates** community engagement and participation by ensuring that services are embedded within the local community and respond to real needs.
- Play Hubs promote inclusion, respect for diversity and equity by incorporating space for social interaction and providing inclusive services to all members of the community.



[2] The WHO European Health Equity Status Report Initiative.

Further information

Cortellesi G. Stanislav D, Kernan M, Trikic Z, Harpley J. TOY for inclusion toolkit. A step-by-step guide to creating inclusive early childhood education and care (ECEC) play hubs for all generations. Leiden: TOY for Inclusion; 2018 (https://www.reyn.eu/resources/toy-for-inclusion-toolkit/, accessed 6 March 2019).

Daniel S, Trikic Z, Cortellesi G, Kernan M. What works guide: ECEC play hubs – a first step towards integration. Leiden: TOY for Inclusion; 2018 (in Italian; http://www.21luglio.org/21luglio/wp-content/uploads/2019/01/What-Works-Guide-ITA-pg-separate.pdf, accessed 6 March 2019).

Bernat A. The rights of Roma children and women in Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, and Serbia: a comparative review and further analysis of findings from MICS surveys in Roma settlements in the three countries. Geneva: United Nations Children's Fund; 2015 (https://www.unicef.org/eca/reports/rights-roma-children-and-women, accessed 6 March 2019).

Irwin LG, Siddiqi A, Hertzman C. Early child development: a powerful equalizer. Final report for the World Health Organization's Commission on the Social Determinants of Health. Geneva: World Health Organization; 2007 (https://www.who.int/social_determinants/resources/ecd_kn_report_07_2007.pdf, accessed 6 March 2019).

World Health Organization
REGIONAL OFFICE FOR Europe

Health & Living Conditions

Health & Social and Human Capital

ClairCity: citizen-led air pollution reduction in cities

Description of the intervention

Air pollution is linked to 7 million deaths worldwide every year, and those with the fewest resources are more likely to be exposed to and affected by higher levels of ambient air pollution. With two thirds of the world's population expected to live in cities by 2050,[1] health-friendly urban areas are vital for reducing inequities in resources and for improving health.

Engaging citizens can have positive effects on initiatives aimed at tackling primary health issues, such as air pollution. However, reducing air pollution requires coordinated action at many levels: businesses, community organizations, local authorities and national governments all have crucial roles in facilitating behavioural change both in their own organization and in citizens.

ClairCity is a four-year project (2016–2020) based on a bottom-up approach. It represents a novel way to develop an inclusive strategy to tackle air pollution through the engagement and participation of citizens. The project increases citizens' awareness about what is happening in their city, the main problems, and what they and their community can do to improve the living environment. This is achieved by working directly with communities, local authorities and 16 partner organizations, including universities, government agencies and multinational nongovernmental organizations. The project aims to bring citizens into the heart of air quality and carbon management processes across six European cities and regions: Liguria Region, Italy; Amsterdam, the Netherlands; Sosnowiec, Poland; Aveiro Region, Portugal; Ljubljana, Slovenia; and Bristol, United Kingdom. It is based on a participatory approach to **improve** air quality and reduce carbon emissions by quantifying and identifying citizen behaviours to:

- **enable** societal change for healthy futures
- **give** residents a voice in deciding the best options for their area
- understand how citizens want their cities to develop.

To make the initiative as accessible as possible, the project has developed ClairCity Skylines, an **innovative** online game that is promoted alongside citizen workshops, events, schools activities, a business-focused app, surveys and video projects. This combination of activities is designed to include in the project those citizens who may not already be engaged with the issues of air pollution and climate change. This maximizes citizen **support** for measures to improve air quality and reduce carbon emissions and clarifies the role of citizens in developing regional and local policies.

How the case study creates the conditions to prosper and flourish and reduces the barriers that are holding people back in health and in life

1. More than 5000 people who took part in the initiative will **inform** the development of city-specific policy packages in which the terms clean air, low carbon and healthy future are defined and quantified with the aim to **accelerate** actions to improve air quality.
2. The interactive activities (e.g. apps and virtual games) being developed for each of the project partner cities/regions are innovative ways to **engage** more people in the project.
3. Supporting community action will help to achieve results that will provide policy lessons at the city, national and European Union levels to **influence** policy-makers.

[1] 2018 Revision of world urbanization prospects. New York: United Nations Department of Economic and Social Affairs; 2018 (https://www.un.org/development/desa/publications/2018-revision-of-world-urbanization-prospects.html, accessed 27 April 2019).

Relevant HESRi[2] indicators

- Annual mean PM10 concentrations[3]
- Access to green space
- Perceived ability to influence politics

Links to HESRi policy action areas

Living conditions

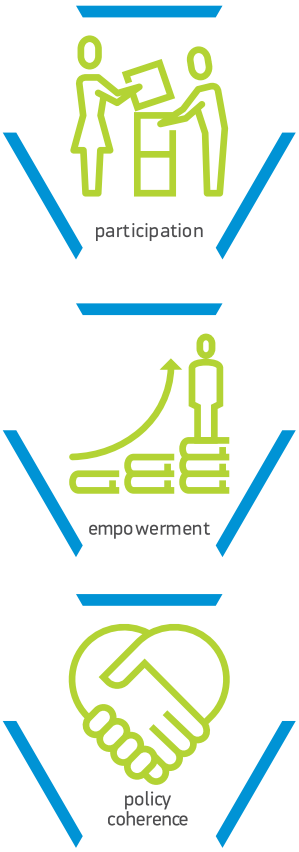
- In all, 91% of the world's population lives in places where air quality exceeds WHO air quality guideline values. Poor air quality represents the biggest environmental risk to health.
- Environmental factors account for a quarter of disease burdens and disproportionally affect those with fewer resources, who are more likely to live in low-quality environments.
- Cleaner air **encourages** healthy activities in green spaces, supports social development and reduces the burden of diseases.

Social and human capital

- The degree to which communities can influence actions that impact their health and well-being is a critical determinant of health and health equity.
- Promoting equitable access to health-enabling environments for all, regardless of socioeconomic background, results in a more equal distribution of power and resources.

Links to HESRi Drivers

- While current approaches to carbon emission reductions and air quality management tend to focus on technology, the ClairCity method is based on citizen engagement and participation.
- ClairCity empowers citizens by targeting activities towards less represented groups, which ensures an inclusive participation process and grassroot community engagement.
- In the project, residents can identify potential unintended consequences and contribute to tackling air pollution and carbon emissions. This positively impacts their perceived level of power.
- The development of an app and virtual games further increased citizen awareness on environmental issues and the negative effects of air pollution on health and well-being. Such awareness contributes to democratic renewal and **accelerates** the process of delivering more socially equitable policies to address air quality and increase health equity.
- By drawing upon the multidisciplinary skills of several project partners and partner cities across Europe, ClairCity enhances and strengthens policy coherence.



[2] The WHO European Health Equity Status Report Initiative.
[3] PM10: particulate matter 10 µm or less in diameter.

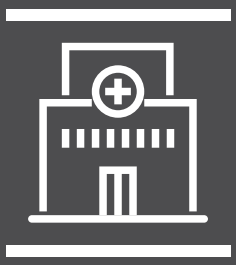
Further information

Evans GW, Wells NM, Moch A. Housing and mental health: a review of the evidence and a methodological and conceptual critique. J Soc Issues. 2003;59(3):475–500. doi: http://dx.doi.org/10.1111/1540-4560.00074.

Uphoff EP, Pickett KE, Cabieses B, Small N, Wright J. A systematic review of the relationships between social capital and socioeconomic inequalities in health: a contribution to understanding the psychosocial pathway of health inequalities. Int J Equity Health. 2013;12:54. doi: 10.1186/1475-9276-12-54.

Peppin Vaughan R. Gender equality and education in the Sustainable Development Goals. Paris: United Nations Educational, Scientific and Cultural Organization; 2016 (Background paper prepared for the 2016 Global Education Monitoring Report; http://unesdoc.unesco.org/images/0024/002455/245574E.pdf, accessed 27 April 2019).

Ambient air quality database application. Geneva: World Health Organization; 2019 (https://whoairquality.shinyapps.io/AmbientAirQualityDatabase/, accessed 27 April 2019).



Health & Health Services

Health & Income Security and Social Protection

Health & Living Conditions

Health & Social and Human Capital

Health & Employment and Working Conditions

The WHO Regional Office for Europe

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

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

Original: English

World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int