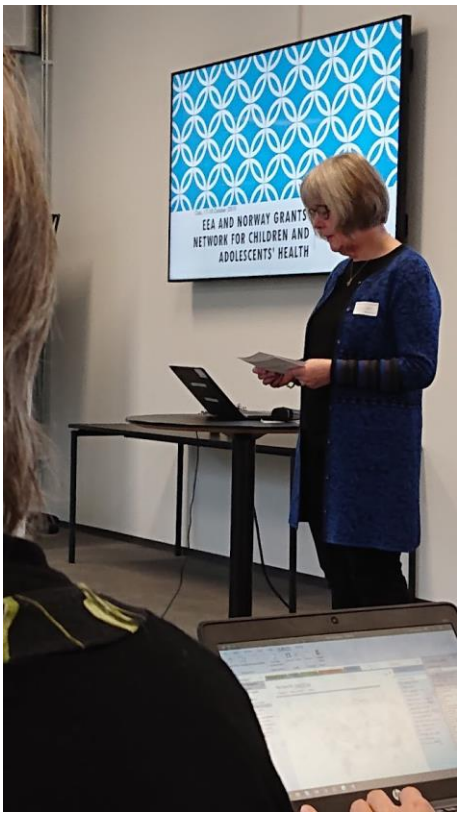
EEA and Norway grants: A network approach to improving children's and adolescents' health

On 17-18 October 2019, the Norwegian Directorate of Health and the Norwegian Institute of Public Health organized the first meeting of the network for children and adolescent health of the EEA and Norway grants. This was held at the Norwegian Directorate of Health Office in Oslo, Norway. Participants included representatives from government at national and regional level, researchers, and public health practitioners in the field of child and adolescent health from the countries of Norway, Estonia, Lithuania, Poland, Czech Republic, Malta and Romania. Representatives from the EEA and Norway Grants Financial Mechanism Office (FMO) and EuroHealthNet – both based in Belgium – were also present. The aim of the meeting was to lay the foundation for a new network focused on children and adolescent health. During the project period 2019-2024, the FMO noted that a number of projects were focused on child and adolescent health. As such, it was proposed to create a network of these pre-selected projects so that they could exchange experiences and learn from one another's approaches, activities, and outcomes.

DAY ONE: Setting the agenda – the European and Global frameworks for prevention in primary health care



A formal introduction to the meeting was given by Øyvind Giæver, Director of the Department for Social Determinants of Health at the Norwegian Directorate of Health. The NDOH, as well as the Norwegian Institute of Public Health, have a history of bilateral relationships between the represented countries as donor partners. He noted that he was very pleased to see the seven countries represented today – as well as to have other representatives from abroad and from various organisations within Norway. He noted that the network would only be as useful as we are able to make it together, and that hearing each country's challenges and successes would be an important first step. He wished the participants success for the meeting and for the network and welcomed Anne Grethe Erlandsen to present.

Anne Grethe Erlandsen, the State Secretary at the Norwegian Ministry of Health and Care Services, welcomed all participants to this first network meeting. She noted that she was very pleased that the Norwegian donor partners had taken this initiative and that there were so many countries represented. The EEA and Norway Grants are about learning from one another and building capacity for the future. Given that we share international commitments, such as the Sustainable Development Goals (SDGs), we must work together to fulfill them. The main goal in Norway is SDG 3.8 on Universal Health Care. She noted that achieving this goal required adequate primary health care and political will. To that end, she noted that Norway signed a resolution to strengthen primary health care last month during the United Nations meetings in New York. The resolution encouraged countries to give health professionals empowerment and sufficient capacity to deliver for the needs of populations and individuals. The EEA and Norway Grants can play an important role in fostering dialogues between European governments and knowledge exchange, as well as incentives to establish partnerships between experts. She stated that societies do not automatically gravitate towards health and health equity, and that we needed to emphasise health equity as a principle that underpins everything we do. She highlighted the Finnish Presidency of the EU, with its focus on the 'economy of wellbeing' as an important reminder that economic and social factors mutually contribute to one another and that EU member states have commitments beyond the single market. She wished the participants a good and productive first meeting and hoped that some of what would be presented by Norwegian partners would be inspiring and useful to the other countries. She closed by stating that she hoped this was the first of many meetings of this network.

National guideline for health promotion and preventive work in the child and youth health centres and school health service, 0-20 years

Siv-Lise Bendixen Stærk from the Norwegian Directorate of Health presented the Norwegian national guidelines for health promotion and preventive work for children and youth. She noted that health services are predominately delivered by municipalities and that the number of municipalities in Norway would be undergoing a dramatic change in 2020. As in other parts of Europe, the Norwegian population is increasingly ageing and becoming more urban, with 8 of 10 Norwegians living in urban areas.

The legal basis for municipal health services for children and youth is The Health and Care Services Act. The Patient and Users' Rights Act also gives children the right to care and parents the obligation to ensure children receive medical checks. While the consultations are not mandatory, there is follow-up with non-adhering families.

Municipal health services for children and youth include health centers and school health services, as well as general practitioners' offices, maternity services and other relevant services, including dental care, institutional care, habilitation/rehabilitation, substance abuse and mental health care services. The municipalities are also in the process of recruiting psychologists for primary health care as it becomes a required competency in 2020. The purpose of health centers is to promote good mental and physical health, good social and environmental conditions, and to prevent illness and injury. The centers have a low access threshold and are meant to fit all types of people, regardless of background and ability.

The national guidelines for the services offered in health centers and the school health service are based on best practice and use an evidence-based approach and the DECIDE framework. They are available online in Norwegian and in English as a PDF (though an English-language online tool is in development).

She provided a brief overview of each type of service, including pregnancy and maternity services, the child health centers programme of consultations, the school health services, and youth health centers. She noted that the school health services included thorough consultations at 1st and 8th grade levels, and all services were delivered in close collaboration with school management. Topics covered include sexual education; tobacco, drugs and alcohol; nutrition; and working to ensure a safe school environment. Specific work depends on the needs of each school community. The youth health centers are vital providers of information on sexual and reproductive health and rights. The services are adolescent friendly in line with WHO recommendations, i.e. accessible, affordable (free), equitable, appropriate and effective to the adolescent population.

Identified keys to success to the national guidelines and service provision:

- Universal services for everyone: attendance as high as 97%. When everyone attends there's no stigma and the odds of identifying the ones with needs for extra follow-up increases. Everyone is offered basic health services and guidance, but, if needed, families and/or children are offered extra help.
- Services are offered free of charge
- Services are interdisciplinary: with collaboration between health professionals (public health nurses, midwifes, doctors, physical therapists, psychologists) and in collaboration with educational and social services.

In developing national or regional strategies and action plans , there has been significant stakeholder engagement, specifically of children and youth, of professionals in the field, and of the general public. Engagement of children and youth has happened both at national level (e.g. focus groups and youth conferences) and municipal level (e.g. surveys, LEGO-building/drawing groups for young children). The national guidelines, like all national guidelines, regulations and acts, are subject to a public consultation for three months. While not all responses are possible to implement, they are all taken into consideration. To incorporate professional feedback, a working group consisting of government representatives, national experts and a representative, wide spectrum of health professionals in clinical work has been established.

The health services collaborate with other services, particularly for children and adolescents at-risk. Mental health services are available in municipalities, and psychologists are integrated into the services from 2020 onward. Health professionals in Norway have a duty of disclosure to prevent, discover and avert violence or abuse. This means that should a health professional suspect that a child may be suffering neglect and/or abuse, they are obligated to notify child welfare services in line with the Child Welfare Act. This act cannot be applied pre-partum, however, meaning that there are fewer recourses during pregnancy (e.g. suspected mistreatment of the unborn child). Yet challenges remain, as highlighted by the 2017 Norwegian report 'Failure and Betrayal.' It was found that the services were not collaborating and sharing sufficient knowledge to support at-risk children. As a result, there is an ongoing effort to improve cross-sectoral collaboration through projects such as the 0-24 collaboration being implemented across Nordic countries.

In the question and answer session following the presentation, a participant from Estonia asked about preparing nurses for school health education. It was explained that public health nurses receive 1-2 years of extra education which primarily focuses on outreach elements (e.g. ways to talk to specific populations and in-depth training on topics like mental health and sexual education). Yet there is currently a shortage of public health nurses, so sometimes nurses who have not yet received the additional training do need to fill these school health roles. The Estonian participant noted that the quality of such education for Estonian nurses was not strong. In contrast, in Norway, there are required competencies for public health nurses and common learning goals being set across universities (though it was noted that it was an area in which they could also continue improving).

A question also came from a Romanian participant about the contracts with general practitioners to offer free services to compare with the Romanian experience. It was clarified that private general practitioners – as well as other service providers like psychologists – contract with the government. If you see them in a government setting (e.g. youth health center) the maximum out of pocket payment equivalent to €200. Patients can also see these doctors, however, through their private networks. It was also clarified that there is another level of governance between the national and municipal levels. The county governors are the interface between national and municipal level on most issues.

Study Visit, Nydalen child and youth health center

Participants visited the Nydalen child and youth health center, located within walking distance of the NDOH office. They were given a presentation by Barbro Foss, the head of the center. She described the demographics for the center, noting that they predominately served a high socio-economic status area with few immigrants. It is one of the four largest centers in Oslo. The building housed not only the health center, but also district administration, child welfare services, and special education kindergarten services. The health center serves youth from 0-24 years old. The station receives approximately 460 women per year for maternity consultations, and around 600 babies per year for consultations. They noted that they do not yet have sufficient capacity for many home visits, but that they would like to be able to offer more of them in the future. They do offer drop-in visits on Tuesday, Thursday and Friday afternoons where parents can come to the waiting room with any questions. This helps to lower the threshold to reach more people. They also offer a "new families" service for people expecting their first baby (or first baby in Norway) to counsel them on becoming parents. In the context of this service, home visits are provided – the quantity is determined by the family's wishes in consultation with the public health nurses. The clinic, located near a university campus, also receives a lot of patients who come for reproductive health

services. Only services targeted towards teens and adolescents are available during evening hours. The other services are provided from 8:00-15:30 during the week.

The district's school health services include 20 school health nurses, 3 psychologists and one part-time physician who serve 19 schools. They participate in teaching in collaboration with the schools and focus on promoting healthy behaviours and detecting issues of abuse. She noted that obesity is not a primary issue in this district, but rather stress and mental health. She noted that while vaccinations are not mandatory, there is 94-96% coverage in the district. There is also no distinction made between "daycare" and "kindergarten" in Norway – all children 1-5 years of age attend "kindergarten." The school health services are also focused on intersectoral collaboration, noting that 90% of our health comes from our environments. In two of their school health programmes they have an interesting model of interdisciplinary work which uses the public health nurses as well as "environmental aides" (e.g. usually individuals with some training in a field like social work or psychology) who can support the nurses in "diagnosing" and "prescribing" social interventions (e.g. clubs) to children in need.

Participants conducted a tour of the facilities and were offered the opportunity to ask questions. One question from Romania regarded the connection with crisis management and/or special needs services. It was explained that there are two ways to connect with these services, depending on the intensity of the need. Special health services are not organised at the municipal level, and some services are split, meaning that less-intensive cases may be managed at the municipal level while intensive cases are referred to the special services on a case-by-case basis. A participant from Estonia asked about parental education and were told that most of the consultations included a heavy component of parental education. There wasn't normally referral to any sort of special programme, but there is an interest in starting more parent education groups.

Challenges and experiences in how to strengthen prevention in primary health care services for children and adolescents: country experiences

Poland

Marcelina Mroczkowska, from the Polish Ministry of Health, gave some background on the current Polish context, describing the 2015 Act on Public Health. The act, along with the National Health Programme 2016-2020, set basic public health policy and the direction for improving health. The strategic goals include reducing inequalities and the work is conducted through interministerial cooperation with various ministries (e.g. education, finance, environment). Specific Polish institutions (e.g. National Institute of Hygiene) cooperate with the Ministry of Health on implementing tasks related to children and youth.

The main challenges for child and adolescent health include:

- Healthy nutrition and promotion of physical activity: up to 10 % of children (even 1-3 years) are overweight. A 2016 Ministry of Health regulation on school food sales reduced the sale of processed foods in schools. They are also developing workshops to shape proper nutritional behaviours.
- Use of psychoactive substances including narcotics and psychotropic substances, as well as boosters (which are cheaper). Nationwide helpline is called 'Drugs-Drug Addiction' to provide psychological support, information on treatment system, legal advice. Prevention programmes include children and parents.
- Behavioural addictions. Compulsive buying, internet addiction, and overuse of social media are affecting children as young as 2 years old. The Ministry offers a website and a national helpline on these issues. They also have preventive programmes for preschool children and their parents to demonstrate alternatives. There are therapeutic support programmes for people with addiction disorders
- Mental health of children and youth. Prevalence of mental disorders (lack of confidence, critical thinking, societal skills, suicidal tendencies) is increasing. There are therapeutic support programmes for people with mental disorders (support groups, individual counseling, workshops on self-esteem)
- Alcohol consumption. A survey from 2015 showed that as many as 83% of young people 13-15 had tried alcohol at least once. Night alcohol advertising was introduced (so that advertisements run only late at night). There are also educational campaigns to stop the sale of alcohol to young people and preventive educational games for young people (also showing their parents what damages can be caused by alcohol).
- Smoking tobacco products. E-cigs are gaining popularity. Poland is the country with the highest underage population smoking e-cigs (62%). There are many campaigns to combat this with social media, as well as contributions from well-known artists and posters on tobacco products.

Poland's plans for the future include a textbook on primary school pupils on nutrition, addictions, vaccination and first aid. They will also work on behaviour change and self-motivation mechanisms to support a healthy lifestyle and prevent obesity and addiction. They will push strategic tasks in the next National Health Programme, and they will continue their projects through the EEA and Norway Grants.

Romania

Livia Cioran, from the Romanian Institute of Public Health, presented for Romania. She gave a brief demographic overview, noting that Romania still has an important rural population (50%) and that 46.8% of children live in poverty (compared to the EU28 average of 26.9%). They have a social health insurance-based system in which children (and pregnant women) are insured by law and receive health services for free. The primary health care network includes 11000 family doctors and the school-based network has 500 physicians and 200 nurses. The public health network is strong, with 42 public health directorates managing implementation and four national centers for surveillance and communicable disease control, for environmental monitoring, for evaluation and health promotion and statistics. The national health strategy 2014-2020 includes three strategic areas, including public health and health services.

The challenges they face include:

- Insufficient physical activity. Only 23% of children and adolescents meet targets for physical activity (29% of boys and 17% of girls).
- Underage smoking. While prevalence of smoking is reducing in the adult populations, they found an alarming growth in smoking amongst children and youth.
- Underage alcohol consumption. Alcohol consumption starts as early as 9 years of age.

The National Institute of Public Health is doing a study on the health status of children and youth, yet this is complicated by the divergence of health problems between urban and rural areas

The interventions being undertaken include many national health programmes coordinated by various institutions. These include national health promotion campaigns centered on information, education and communication (IEC). There are up to 28-30 campaigns per year implemented nationwide. They also conduct surveillance of health status and health determinants with reports and national periodic studies on the weight and height of children. The community health centers in each district unit are also focused on preventive activities, particularly targeted towards vulnerable populations (e.g. Roma). During the last Norway Grants programme, they also developed guidelines and instruments to translate the materials from Norwegian health centers to the family doctor setting in Romania. These family guidelines with integrated solutions were very useful for doctors and made preventive services easier to offer.

Ileana Botezat-Antonescu, the director of the National Centre of Mental Health and Anti-Drug Action also spoke about a specific project that the centre will implement with Norwegian partners. She described the structure of mental health services in Romania and available human resources as well as the National Mental Health Strategy 2016-2020. She noted that this new project will help them to achieve the strategy, as the activities support development of community-based centres for children and adolescents. There will also be an epidemiological study and a specialist training with education and welfare professionals to raise the competence of the mental health services.

Estonia

Tiia Pertel, Head of the Centre for Health and Welfare Promotion at the National Institute of Health Development, and Kerli Mooses, from the institute of Sport Sciences and Physiotherapy at the University of Tartu, presented on behalf of Estonia.

In Estonia, their goals include achieving local development and poverty reduction through improved health. But the challenges they face include:

- Health inequalities. Inequalities (geographical, socio-economic, etc.) are increasing within and between the regions. They are working on a policy to address this in the next public health act, and it forms one of the main topics in the new national health plan.
- Municipality reform. As in Norway, Estonia also reformed the number of municipalities, offering both challenges and opportunities. They moved from 200 local governments to just 79, which means that each local government now has increased capacity to deal with public health.
- Service gaps
- Mental health was a big topic in Estonia's last project period and it remains a big issue
- Inactivity and obesity are a growing health problem, so they would like to further promote environments where young people play and live in a healthy way

Estonia is responding to these challenges by taking a universal approach, addressing the environmental factors of health beahviour (e.g. school environment). They are also increasingly taking action to the local level and enhancing cooperation between health and other sectors. They are also working to address the most vulnerable groups.

Kerli further elaborated on issues related to physical activity. Only 24% of children meet physical activity recommendations. So the 'schools in motion' programme was launched. It has been constructed working closely with schools and includes tenants of active transport, active lessons, active recess, reform of physical education, and active transport home. Previously, during recess, Estonian school children weren't allowed to go outside and run. They were required to sit inside and be quiet and use the time to rest. So the programme is a paradigm shift which as required the engagement of students and school personnel to get their buy-in. The programme started with 10 pilot schools and has grown to 78. Other schools would also like to enter the programme, but they need more capacity to scale further and make the intervention sustainable. Estonia is also adapting the intervention Toybox, involving 25 kindergartens in project period, and increasing the home support for Toybox to bring in parents more actively. In addition, they are focused on the whole on strengthening capacities in local governments (focused on 20 local governments for the next 2-3 years) and tackling health inequalities.

Czech Republic

Petr Cermak, from the Ministry of Health, presented for the Czech Republic. He discussed the health services affecting children, providing a brief overview of the situation of schools, hospitals, mental health services, vaccination programmes, and socially excluded localities.

Issues he noted included:

- High institutionalisation and medicalization rate for mental health care. There is an ongoing mental health care reform, which started in 2016 and aimed to increase community-based care. Yet mental health issues remain highly stigmatized and there is less focus specifically on children. This is starting to change with the reforms, however.
- Hospitals lack doctors and nurses, but digitalisation may offer limiting the administration burden to some extent. There are also specialised clinics for children, as well as play therapists and hospital clowns.
- Vaccination. While the coverage rate remains relatively high, it is decreasing. There is a new portal with evidence-based information, but population awareness remains low.
- Fragmentation of the childcare services and systems. There are three main institutions governing issues related to children (Ministry of Health, Ministry of Education and Ministry of Social Affairs)

but they need better coordination amongst themselves to improve the early intervention and identification of health and social problems
- Children in socially excluded localities are at higher risk of poor living conditions and increased risk of addiction, mental health problems, domestic violence, malnutrition and other issues.

Planned measures in the Czech Republic include the National Strategy Health 2030 and Education Strategy 2030+. These include a focus on further deinstitutionalization, increased cooperation amongst related professions, more developed screening in maternity hospitals and increased parenting education and skills. Some of the current good practices include free and quality health care, a very low infant mortality rate, and a good system for complaints (e.g., an ombudsman in each hospital, public defenders of rights).

EEA Grants 2014-2021 – Health Programme: Work will start this year and wrap up in 2024.
- We made 4 types of activities for promotion of children's mental health
  - Improving parenting skills
  - Implementing innovative or improved diagnostic procedures and/or treatment methods
  - Providing training and education in the area of children mental health (including for teachers)
  - Promote awareness of children's mental health among children as well as general public.
- We will have two open calls for projects and we have one predefined project: Triple-P evidence-based programme from Australia.

Lithuania
Justina Racaite, from the Ministry of Health, noted that Lithuania faced very similar challenges to those already described by other countries. These included: sleep disorders, low physical activity, early and high consumption of alcohol, high prevalence of bullying, high suicide rates, and low social support.

There are many institutions, as well as NGOs, working to address these challenges. The Child Health Policy is developed by the Ministry of Health, child health monitoring is done by the Institute of Hygiene, child health safety by the National Public Health Centre, and child health promotion by a number of institutions. The Ministry has given high priority to public health, particularly to mental health issues.

For the EEA Health programme 2014-2021, the programme partners are the Ministry of Health and the Ministry of Social Security and Labour. One of the projects to be implemented within Programme is the 'Incredible Years' project, a parent education project also used in Estonia. Lithuania is also developing home visits model and extending youth-friendly healthcare services, noting that it was nice to see that morning how integrated the Nydalen centre was with other social services. They are also working to equip health offices in pre-schools and schools with sufficient methodological tools and materials.

Malta
Cynhia Scerri and Ruth Cutajar, Project Promoters for "Social Inequalities in Health and the Burden of Disease" presented Malta's challenges and priorities. They provided an overview of the demographics in Malta, noting their very high population density and the increasing immigration from Eastern Europe and Africa. Malta's priorities include universal health coverage and reducing inequalities faced by disadvantaged populations.

The main challenges Malta faces in child and adolescent health include:

- Obesity: a major health issue affecting 27% of 11-15 year olds
- 'Low mood': depression and anxiety rates higher than average across 48 surveyed countries
- Lack of education: Highest rate of early school leavers in the EU (19.6%). Increased risks for: diabetes, hypertension, obesity, and mental health

The challenges are being tackled in various ways, including improved food in canteens, child and youth psychiatric services, and change in curricula. This covers the majority of children, but there are also children with special needs. The Norwegian project is intended to support these children.

The Norweigian-funded SIT project is focused on sensory integration. Sensory integration is the organisation of sensations for use. Our sensations help us to learn and move and behave in productive manner. Sensory integration issues are a common comorbidity with children with other challenges (e.g. autism, ADHD, anxiety). This project targets this particular population to improve their learning abilities and to address issues of early school leavers (causes learning disabilities/delays) and low mood. The 2017 National Children's Policy indicated that we needed to focus on these children. Establishing this free SIT clinic means that dedicated therapists will work with children 0-16 years of age. It will start with a screening programme and then sensory integration therapy (individually tailored, play-based)

Norway

Astrid Nylenna, Project Manager on Non-Communicable Diseases at the Norwegian Directorate of Health presented the Norwegian context. She noted that many of the challenges were the same as those mentioned earlier, including:

- Mental health. Mental conditions account for 25% of the burden of disease in children and adolescents
- Obesity/low physical activity. There are also key issues around obesity and low physical activity, mostly related to socio-economic status. While obesity figures appear to be stable around 15-20% at the moment, they may start to rise again.
- Low tobacco use (around 3% between 16-24), but there are increasing rates of smokeless tobacco use by young people
- Social and health inequalities. Norway sees big differences in lifestyle across socio-economic strata which will likely lead to continued health inequalities across the lifecourse.

The Public Health Act: Background, content and application of the Norwegian Public Health Act
Ellen M Paulssen, Senior Advisor at the Norwegian Directorate of Health, presented the Public Health Act. In 2012, a major health reform was undertaken to create more coordination between primary and specialised health care, while simultaneously putting further emphasis on public health and prevention beyond the health care system. It resulted in two new acts: the Public Health Act and an at on health care services in municipalities. The act's purpose is to contribute to societal development that promotes public health and reduces social inequalities in health. The act facilitates long-term, systematic public health work. This makes it a whole-of-society approach with universal measures. The act, and a brief summary, are both available in English (LINK THIS).

In the act, the municipalities are the most important actors, providing public health services, ensuring cooperation across sectors and conducting continuous overview. The national level has a key responsibility to support the municipalities with guidance in implementation, sharing good practices, and helping with 'health in planning.'

While it is difficult to measure the success of the act yet (since it started only in 2012), there are positive early indicators showing improvements in key areas. Public health figures more prominently in planning now and many municipalities have hired a public health coordinator to support intersectoral collaboration.

Public Health Profiles and the public health barometer

Heidi Lyshol from the Department of Health and Inequality of the Norweigian Institute of Public Health presented the Public Health Profiles. The public health profiles were designed following the 2012 Public Health Act which required counties and municipalities to have *sufficient* overview of health conditions and influencing factors. This information has been deemed to mean information from central and county health authorities, information from municipal health and care services, and knowledge about factors and trends in the environment and local community than may affect the health of the population (e.g. economic transitions).

The main data sources include various registries, surveys, and other population records. The system NorHealth, translated into English, means that this data is available for an international audience, as well. The data is transformed into the public health profiles, which are designed to be accessible to the public, presenting the data in easily-accessible formats for the public and policymakers. A public health report is also published every four years, and there are factsheets and articles in the interim. The annual process includes: indicator selection and standardization, addition of new indicators to NorHealth, extraction of data for public health profiles and reports, and publishing. This process is largely automated as the department is very small. The resulting profiles include barometers that show how a municipality ranks in comparison with others and with the national average across 34 indicators. The text goes through a significant revision process to ensure that the profiles are both scientifically accurate and also accessible to the general public. While the profiles are well-received and generate significant media attention, they do sometimes result in too much political focus on 'red dots'/'green dots' (indications that a municipality is above or below average on a certain health indicator). It is important that policymakers and the public are encouraged to look beyond the red and green to think about trends.

Following the presentation, a Polish participant asked whether the data was used to make explicit political recommendations. It was clarified that the data is not used for such purpose, but the specific inclusion or exclusion of certain indicators was already an implicit form of setting policy in itself.

Public Health Work in Norwegian Municipalities

Indre Østfold Municipality

Linn Haraldstad, Public Health Advisor/Coordinator from Indre Østfold, gave an overview of her work within her municipality. She started with an overview of the demographics of the municipality, located in Southeastern Norway on the border with Sweden. There are approximately 45.000 residents, and, statistically, the living conditions are below the Norwegian average. They have higher inequalities, greater school dropouts and greater differences in life expectancy.

The Public Health Act was key for the municipalities as it gave them the authority to act on a much broader scale (e.g. social inequalities) than pre-act. A primary part of her job is to collect statistics and data to understand what is working well, which populations should be prioritised for support and, in

general, to make evidence-based materials. This often requires making phone calls and site visits. They are prioritizing three life phases at the moment: 1) conception to age 3, 2) graduation from high school, 3) postponing sickness in old age.

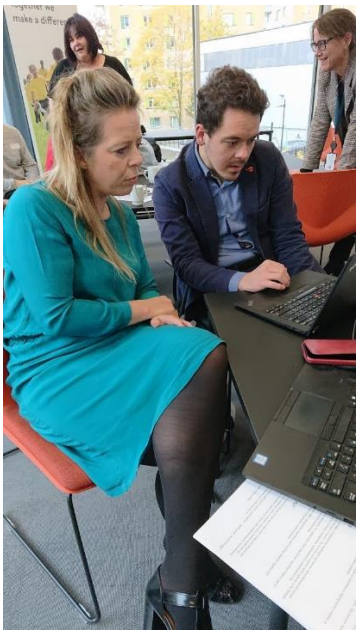
Public Health Coordinators also do significant collaboration with other sectors to ensure that health is being considered in all sectors, to 'describe consequences' of certain actions or policies for policymakers, and to ensure that the municipality plans for a more sustainable society and better future for all.

Bærum Municipality

Nina Kolbjørnsen, Public Health Coordinator, echoed Linn's points, noting that her job was to be "somebody." It is often said in meetings that "we need somebody to do X?" or "is there someone who could X?" She noted that the "somebody" is usually her in a coordination role. She also noted that her job is to be a "friendly reminder" that health needs to be considered in all policies and planning.

She gave a brief description of Bærum, which, unlike Indre Østfold, is relatively wealthy. They are the 5th largest municipality in Norway and they have a relatively high percentage of immigrants (17.4%). She noted that, generally, health statistics were very positive, and that politicians sometimes wondered about the need for a Public Health Coordinator. But she emphasized that challenges remain, largely around health inequalities, and mental health and alcohol use by youth.

Since 2012 and the installation of a public health coordinator, there has been more targeted planning of health services, and some health services are receiving more resources than they did previously. This was an 'earthquake' when it was first introduced, as social inequalities have been a politically sensitive issue. It has also affected the way that they work in that social services have more information about the health status of the children they are working with. Specific projects (e.g. parental education) have also been initiated in some areas, and the health act has given the mandate to get more engaged in different sectors and to receive additional funding to subsidize public health work. This has made it easier for the Public Health Coordinator to approach local schools and offer small grants to undertake specific health promoting projects. An additional challenge is evaluation. There is not yet sufficient evaluation of the work being done, but she hopes that this will change.



Digital Health Applications in Norway

The Slutta Mobile Application for Tobacco Cessation

Astrid Nylenna gave this presentation on behalf of Ove Jørgensen. The Slutta, or "Quit" application has been one of Norway's greatest successes in tobacco cessation in recent years. It has been an anomaly because it has topped the health apps in Norway for many years – 800,000 downloads since 2012.

The app is under constant development. The 2018 version used open source code which means that the app can be replicated in other settings. Part of the success of the app has been constant revision and addition of new features. The app was developed to replace the quitline, which was being used less and less (and which was relatively high-cost as it required staffing people for phone calls). As Dr Nylenna noted, "Having an app in people's pockets all the time was what we wanted to do. We know that many have tried to quit and very few succeed if they don't have any form of help or assistance. If you accept just some form of assistance you can double or triple your chances of successfully quitting." The app is free with no geographic limitations. People write their quitting success stories in the reviews in the iPhone app and Google Play. If any participants are interested in receiving more information about the app or its open source code, they should write to Ove at ovj@helsedir.no.

The Estonian participants asked how the Slutta app was promoted. Dr Nylenna explained that once it got up to the top of Google Play and the App Store health app rankings, it tended to self-promote. But the NDOH has also promoted the app with a lot of health professionals and made business cards with QR codes linking to the app. Each time a national smoking cessation campaign is launched, they also talk about the app. It is not currently available in English, but, again, the source code is free so it could easily be translated.

DIGI-UNG

Adélie Dorseuil, from the Norwegian Directorate of Health, presented DIGI-UNG (or 'Digi-Youth') to the participants. It consists of coordinated digital services (e.g. website, chat, digital appointments) centered on youth. Based on user insight conducted in 2018, conducted in parallel with service provider insight, the team found that youth agreed on a lot of issues, but also had many differences. They found broad consensus that certain things didn't work when offering services to youth. These included sectorized, confusing and fragmented digital services. While everyone is trying to offer a digital option, it is difficult to take advantage of them when they do not communicate and youth cannot get an overview of what is available. They also stated that weak digitalisation of public health services represents a barrier for youth to use services. For instance, if they can only access the services by leaving school early and visiting the public health office or centre, they are unlikely to do so. Generally speaking, youth agreed that the following did work to make health services more accessible:

- Mobile-based interfaces
- Adapted opening hours for youth access (e.g. late evenings, nights)
- Updated design (if the interface appears out-of-date, youth consider the information to also be out-of-date)
- Simple words and universal design
- Positive focus (as one young person said, "You know, I wouldn't really go to a website called depressed.com")
- Safe and fact-checked information
- User-friendly, seamless experience with anonymous entry and everything in one place. The audience was reminded that, for teenagers, many of the health questions they want to ask may be highly sensitive and embarrassing, so they really do not want to be identifiable when they are asking

Ung.no ('young.no') brings together a lot of information from different sites. It is a question and answer forum in which youth ask anonymous questions which are answered by experts from across the country in various social sectors. It is one of the most visited webpages in Norway, despite only being tailored to youth. In one survey, they found that 95% of school kids knew about this page. Since a repository of all questions is maintained, Ung.no usually shows up in the top results in Google when youth search health-related questions. Thus a Google search often becomes and Ung.no search.

Adélie stressed that youth have very different needs and categorized them into three broad levels which could have different engagement with the Digi-Ung services.

- Level 1: One-way information and one-time assistance. For instance, "My family is always broke lately – is there any help available? What are my rights?" (16-year-old girl)
- Level 2: Anonymous dialogue and interaction. For instance, "I dropped out of high school and had trouble at home. I started looking for a job but would like to finish my studies. I struggle with motivation…what can I do?" (18-year-old boy))
- Level 3: Individual help and follow-up. For instance, "I get beaten by my father. The police and protective services aren't doing anything. I also get hit and bullied at school. I get suicidal thoughts…I don't know what to do." (13-year-old girl)
    - In Level 3 cases, the Digi-Ung representative who is chatting with the young person would need to know who she is to provide more intensive services. The girl can be encouraged to log into the service, and, once identified, the DIGI-UNG representative can support her to engage the right services and support.

DIGI-UNG has many different features such as articles, Q&A, search, chat, e-learning and e-consultations and they plan to continue adding relevant formats such as graphics, podcasts, and videos. They also want to decrease the response time for questions and create a search feature for a national register of help services.

There are currently many actors engaged in the service, including NDOH, the Directorate for Children, Youth and Family Affairs, and the Directorate of e-Health. Many actors will be engaged in the future,

including the Norwegian Association of Local and Regional Authorities and the Directorate for Work and Welfare. The management structure includes a user council (consisting of youth) and an architecture council (responsible for ensuring the seamless interface for users). The biggest challenge they face in expansion of the service? The siloed nature of public budgets vs the seamless user experience youth demand. They find it is very difficult to encourage certain departments and personnel to 'work for free' since they aren't receiving a budget from them. Ultimately, the public sector needs to want the same thing at the same time and the same place as youth.

During the question and answer session, the representative from the Norwegian Cancer Society asked about the role of civil society. It was clarified that they are key actors in this system as they are often writing the content for articles, answering youth questions, and recruiting youth for the user council. A Polish representative asked if the services were currently available in English. It was clarified that they attempt to answer questions in the language in which they are asked (including Sámi). They are interested to work in many more languages and they are working with a page called Zanzu to achieve this.

Experiences from the SYNERGY Network

Freja Ulvestad Karki, Project Manager in the Norwegian Directorate of Health, presented the SYNERGY Network, which is the EEA/Norway Grants Network against Gender-Based and Domestic Violence. This network has been highly influential in deciding to launch the Network for Child and Adolescent Health.

Freja began by stating that "The proof of the pudding is in the eating." From the outset, it is important to understand what the benefits and advantages of being part of the network are. She explained that the scope of the SYNERGY mandate is in their title: they are focused on both public health and violence issues and sharing reflections and experiences from various countries. This requires both intersectoral domestic collaboration (e.g. between the Ministry of Health and the Ministry of Justice) as well as international collaboration.

She stated that violence is a problem in the WHO Europe region, and WHO Europe has produced a lot of documents and resources in this area. The latest document they have developed is called 'Inspire.' The countries in the SYNERGY network are also focused on these areas. They had seen the benefits of bilateral relations with countries, but realised that a multilateral approach would bring even more inspiration and motivation. The most recent meeting was held last week in Prague and the next network meeting will be held in Estonia. As the meetings have continued, there has been an evolution in the content. First participants needed to get to know one another and develop trust, as well as to understand one another's roles and responsibilities and competencies. They couldn't take for granted, for instance, that a ministry in one country would be identical in function and scope to a ministry in another country. This is one of the key benefits of networking. As time has gone one, the meetings' objectives have become more practical and concrete, as participants come to understand what kinds of materials and products can be adapted and applied to each context.

SYNERGY networks around existing events (e.g. EU Presidencies), receives and shares updates on relevant topics, strengthens bilateral and multilateral bonds, creates sustainability in our work, supports better informed outputs and outcomes, disseminates feedback in our own network, and gives inspiration.

In sum, Freja stated that "Proof of the pudding is in the eating and we are eating all the time." She noted that the Department of Global Health had worked very hard on this network and she hoped that this additional public health network for child and adolescent health would also be established.

Reflections from Day 1

At the end of the first day Erlend Aasheim, Director of the Department of Global Health at the Norwegian Directorate of Health, led a very brief session of reflections on the day's content. He noted that a number of common challenges had been identified across countries, and we should use this as an opportunity to look for common solutions. Some of the key challenges identified included: mental health, substance abuse, and lack of physical activity.

The question will be how the network can contribute to discussing, designing and implementing common solutions. The participant from EuroHealthNet noted that it would be helpful to first have more information on the specific child and adolescent health projects being funded during the project period to look for specific areas of focus. A Romanian participant noted that, in the next network meeting, it would be valuable to hear what other EEA/Norway Grants beneficiaries have achieved and what they are

going to do with their future grants to establish more multilateral relationships. She also said that it would be interesting to better understand how neighbouring countries are implementing their EEA/Norway grants in real-time and to also see how they manage their finances and reporting.




DAY TWO: Welcome and Introduction

Dr. Erlend Aasheim welcomed participants back for the second day of the meeting and introduced Marianne Bergsaker from the Norwegian Institute of Public Health to make some remarks. Marianne described her experiences working in vaccination and global health and some of the successes that they have had building networks in this field. The first she described was creating a platform to meet with health nurses regularly to discuss vaccination issues with main focus on communication and the childhood vaccination. In 2006, after an idea from Sweden, they arranged a 2- day's vaccine conference for Norwegian health personnel. This has become a yearly happening, attendance growing from approximately 100 participants the first year to over 500 people attending at this year's conference. She also presented an EU-study network on attitudes to vaccines and vaccinations which brought together nine countries. Through this study, they were able to get information about vaccine hesitancy in Norway as well as building collaboration with other countries. They also participate in the Nordic Vaccine Meeting, a rotating biannual meeting that has served as a platform to share experiences and best practices amongst participating countries. Finally, they have begun to collaborate more with other countries to conduct literature reviews prior to introducing new vaccines and developing informational materials. This has all been extremely useful and helped Norwegian vaccination efforts significantly.

How to build a network? Experiences from EuroHealthNet

Alison Maassen, Senior Coordinator at EuroHealthNet, gave a presentation following the themes of successful networking. EuroHealthNet is the European Partnership for Health, Equity and Wellbeing. Its members are predominately public health agencies, national and local authorities, and research institutes. Their mission is to improve and sustain health across Europe through targeted action on social determinants of health and health inequalities.

Ms Maassen presented six keys to building a sustainable network. They were:

- Clear, guiding mission and objectives
- Regular opportunities to meet and share experiences
- Organisational and individual capacity building and exchanging lessons learned
- Amplifying one another's work and facilitating new connections and opportunities
- Building a reputation and trust
- Assigning roles and responsibilities and adequately resourcing them

These keys were then illustrated with some examples from EuroHealthNet's work. For instance, she stated that the mission and objectives of the network must be broad enough to appeal to the members' unique

priorities, mandates and capacities while still remaining targeted enough to define and align our collaboration. In EuroHealthNet's case, 'health inequalities' are the thread which ties together the various activities and initiatives conducted with members. She also noted that it was important to be very clear and pragmatic about assigning roles and responsibilities for network members, so that they felt ownership and initiative to help achieve the network's objectives.

Ms Maassen, responsible for developing the meeting report, also asked the following questions of participants to capture their responses for the report:

- How could the network support the implementation of EEA and Norway grant projects?
- What are relevant topics for future meetings of this network?
- How can the network support you to identify opportunities related to children and adolescents health?

During the question and answer session, a question was received from one of the Polish participants who asked for examples of work being continued over time. Ms Maassen clarified that not all of the activities of the network were continued over the long-term. Some projects did end, while contributing to the network's overall knowledge, while others continued in various formats, whether as EU-funded projects, working groups led by members, and/or themes for study visits and workshops.

Group discussion on the Network's proposed terms of reference

The questions raised for discussion during Ms Maassen's presentation – as well as the draft terms of reference – served as the starting point for both small-group and plenary discussion amongst participants about the overall objectives and functioning of the new network. Some common points and specific interventions are captured below.

- Participants felt that future meetings should revolve around specific topics, specifically those which have been named as common challenges across the different countries (e.g. physical activity, mental health). Other specific themes mentioned included:
    - Lithuania:
        - The theme of communication and publicity would be interesting – how to attract your youth to receive services? We have them, but not so many people come to receive them. We could share good practices/bad practices.
        - Measurement of effectiveness of projects and activities. How is evaluation being done?
    - Estonia:
        - Physical Activity for children (they noted that they could organise site visits on this topic, as well)
        - We are also interested in health promotion and prevention in local communities (how to support, how to promote).
    - Czech Republic:
        - Mental health (a logical option since it receives the most funding in Czech Republic at the moment).
    - Poland:
        - Prior to selecting a topic, it would be helpful to determine at what level we want to focus: national? European? If there are common tools being used in child and adolescent health across Europe we could measure the impact in different countries. We are also specifically interested in mental health for youth and tobacco consumption (not just for youth). But there are many other topics, as well.
        - Vaccination – good practices on addressing vaccine hesitancy would be great
    - Malta:
        - Early identification of mental health problems for early intervention and prevention
        - Sharing experiences on health promotion education and prevention
    - Romania:
        - We suggest to go home and consider further and to send a response by email with the most important problem we're facing. But it would be good to remain in touch with participating countries between now and the next meeting to continue to discuss our strong and weak points.
- Participants from Estonia noted that it would be useful to invite relevant researchers in the selected topic area(s) to attend the meetings, as it would bring more expertise into the discussion and also allow universities to build greater connections to improve their opportunities for collaboration.

- Estonia also noted that it would be helpful to bring in local government representatives (similar to the Public Health Coordinators who presented from two Norwegian municipalities yesterday). Perhaps the meetings could have one day focused more on the 'core' EEA/Norway Grants-affiliated representatives and the other day could be open to a wider audience of stakeholders (e.g. local government, implementation sites).
- The participant from the Czech Republic highlighted that having more diversity of participants in the meeting would bring more value. In the previous network they had of Programme Operators (POs), he noted that by the 2nd or 3rd meeting they already knew much of what their colleagues were doing and the meetings became less useful. Bringing in thematic experts would keep the meetings fresh and relevant over time. He also noted that it would be illuminating to have site visits over the course of the meeting.
- Several participants voiced concern about the financing of the meetings. The representative from the Financial Mechanisms Office suggested that the bilateral funds could be a source for this funding, but it would need to be discussed and determined on a case-by-case basis. She suggested that the same model used for the PO network could also be applied here.
- Several participants also voiced concern about the overall administrative burden that these meetings may entail, particularly when dealing with invitations to officials and managing various funding and approval processes. They noted that these types of meetings often need a number of months of advance planning and that it can be useful to have a split in responsibilities between the administrative tasks and the content tasks.

As the conversation moved more explicitly into a review of the Terms of Reference, the following points were captured regarding the various sections:

1. Background
    - A participant from Poland noted that it would be useful to establish exactly which actors the network would include. It was clarified that this information was written in the Organisation and Roles section and that it may depend a bit on the needs of each country.
    - The Czech participant underscored the importance of having a broader network than just programme operators, so ensuring that there was a role for experts to also participate in the network. He suggested that each country should think about the format for engaging with relevant stakeholders for network meetings and on network topics
2. Objectives
    - The EuroHealthNet participant suggested that “Keeping health on the agenda for the next funding period” be added as an explicit objective of the network. This could help the network have more sustainability over the long-term and would help network participants focus on demonstrating the network’s value both to EEA and Norway Grants officials as well as to their own national governments.
    - Participants from Romania stressed the importance of the network’s stated objectives of exchanging experiences, developing new cross-country partnerships, and contributing to sustainable and effective programme implementation. They noted that the EEA and Norway grant project implementers needed to take part in the meetings and that these meetings would be a way to meet potential new partners for other projects and funding opportunities. They noted that they had already heard some interesting things
    - regarding mental health during this first meeting that would help them with their work on deinstitutionalization.
3. Form and output

- On form and output, it was reiterated that the participants of the network should be defined, possibly as a 'core team' of participants with a rotating series of experts and stakeholders depending on each meeting's selected topic(s).
- It was also suggested that some very brief text be added on how prospective members can enter – and exit – the network if need be. The procedures do not need to be complex (e.g. perhaps just an email notification).

4. Main activities
    - Participants were generally in favor of the rotating meetings and a number of proposed themes were discussed. The preliminary plan for network meetings 2019-2023 was not finalised. Czech Republic and Romania both indicated that they would likely be able to host in 2021 or later. It was suggested that Spring 2020 may be a very ambitious timeline for the first meeting as the countries will be very busy launching their projects during that period. In any case, it was stressed that hosting the meeting needed to be a 'useful exercise' for the host country, as it may entail significant additional work.
    - It was also suggested that the participants have a way to remain in regular contact in-between meeting dates. Two ideas of hosting regular webinars (e.g. to present projects in more detail) and a quarterly newsletter (e.g. to share successes and challenges and important information about coming meetings) were raised.
    - In general, participants felt that it was useful to have more information on a regular basis about the other countries' EEA and Norway Grant projects and their implementation.
5. Organization and roles
    - Participants agreed that a more thorough definition of roles in the network would be useful, along with timelines with pre-established dates to ensure commitment.
    - It was also suggested that both technical and political aspects could be covered in the meetings. One way this could be handled is to have 'parallel' meetings during the meeting period so that technical experts could meet and discuss and political experts could simultaneously meet and discuss.
    - It will also be important to define our platform(s) for communication – who would have responsibility? Should all network members be in all communications, or should we also establish particular groups for particular topics?
    - A suggestion was received from Poland to create sub-networks within the network (e.g. for tobacco), though a counter-suggestion raised concern that this fragmentation of the group could generate communication concerns. From the name of the network, it is not so clear that it should also include technical experts, rather just thematic experts in child and adolescent health, so perhaps the name could be reconsidered.
    - Several concerns regarding funding remained from participants. They were responded to by the FMO Officer. She said that they envisaged a funding model similar to the SYNERGY network. Participation could potentially be covered by the bilateral funds under each programme. Meeting host countries may also potentially be able to apply to their national agencies to use bilateral funds to host meetings/participate in meetings. But this will depend on the national context and whether or not programme funding has already been depleted.
    - Lithuanian participants asked for clarification about who would be leading the network. For instance, who should they write to if they have an issue? They assumed that it would be Norway. The Norwegian participants did not necessarily want to see Norway

as the main influencer. It was suggested that the DPP should work with the organising country in planning the meeting in a coordination, not leadership, role. Each country would be responsible for each meeting, with support from the DPPs.

The NDOH thanked the participants for their feedback on the terms of reference and stated that an updated version would be shared with participants along with the meeting report. In the next meeting, the terms of reference would hopefully be finalised and approved.

Several other outstanding points remained, including date, location and topic for the next network meeting, but it was agreed that these would be sent out with the meeting report for further discussion with participants.

Closing remarks

In the meeting's close, participants thanked the NDOH for hosting the meeting and taking the initiative to establish this network. The Norwegian Cancer Society representative stated that he had learned a lot about the magnitude of work that lies ahead for the network, noting that the challenge of coordination of services was one of the biggest issues. He said he is looking forward to how the network will be rolled out and what we can learn from one another. Mr Aasheim thanked the participants for their engagement and reminded everyone of the core reason that they were at the meeting: to address our challenges in child and adolescent health more effectively together. He closed by saying that they looked forward to remaining in touch with participants and beginning the planning for the next meeting.