GLOBAL GOOD PRACTICES ON HEALTH FOR LOCAL GOVERNMENTS

İZMİR METROPOLITAN MUNICIPALITY

izpa İzmir Planning Agency

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GLOBAL GOOD PRACTICES ON HEALTH FOR LOCAL GOVERNMENTS

CONTENTS

FOREWORD

Local governments play a decisive role in protecting and improving public health and in reducing health inequalities. As the institutions closest to people's daily lives, municipalities develop good practice projects in the field of health, producing inspiring solutions at both national and international scales.

The 50 good practice examples in health presented in this book, drawn from around the world, demonstrate how local governments across diverse geographies engage with their communities and address health through a holistic approach. The examples have been selected across a broad spectrum, from preventive health services to age and disability-friendly urban policies, from supporting mental health to environmental health projects, from promoting healthy lifestyles to models of social solidarity.

Our aim is not only to document good practices, but also to provide examples and guidance for local governments, decision-makers, and practitioners. Successful solutions developed at the local level, aligned with the Sustainable Development Goals, contribute to making societies more resilient, equitable, and healthy.

By revealing local governments' good practice examples in health, this book seeks to support inter-municipal learning processes and open up new horizons. We hope these examples will serve as a strong guide for all municipalities on their path toward building healthier cities.

Dr. CEMİL TUGAY
Mayor of İzmir Metropolitan Municipality

INTRODUCTION

According to the constitution published by the World Health Organization (WHO) in 1948, health is "a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity" (WHO, 2025a). While this definition frames health as well-being in multiple respects, a historical perspective reveals that the emphasis on mental and social well-being, as well as the body of work in these domains, has increased in recent years.

Health promotion and improvement comprise a comprehensive social and political process. These efforts not only include actions aimed at enhancing individuals' skills and capacities, but also interventions to change social, environmental, and economic conditions and thereby mitigate their impacts on population and individual health. Health promotion and improvement is the process of enabling people to increase control over the determinants of their health and thus improve their health. Public participation is essential to sustaining all of these efforts. "Health Promotion" also refers to the combination of health education aimed at producing behavior change in the protection and improvement of health, together with organizational, economic, and environment-based supports (T.R. Ministry of Health & WHO, 1998).

Public health, through core functions such as assessment, policy development, and assurance, aims to improve health; through protection functions, it seeks to prevent diseases and injuries (Caron et al., 2023). Disease-prevention strategies developed in public health are as follows (Table 1) (Kisling & Das, 2025).

Primordial Prevention	Policy measures; addressing the social determinants of health; social policies
Primary Prevention (I)	Interventions before disease emerges
Secondary prevention (II)	Early-diagnosis methods, screenings, treatments
Tertiary prevention (III)	Rehabilitation; adaptation to daily life; social reintegration
Quaternary prevention (IV)	Preventing unnecessary/excessive treatment and medication use

Table 1. Prevention of Disease, Patient-Physician Relationship (Büyükokudan & Avcı, 2023; Jamoulle, 2015.)

Patient	Physician: not ill	Physician: ill
feels well	**I** An action taken to prevent the cause of a health problem or to remove it from the environment before it emerges in an individual or in society. (Example: immunization).	**II** Measures taken to detect the development of a health problem in an individual or in society at an early stage, and to shorten its course and duration. (Example: hypertension screening).
feels ill	**IV** The action of identifying a patient or a population at risk of over-medicalization, protecting them from invasive medical interventions, and ensuring ethically acceptable care procedures. (Example: preventing polypharmacy and promoting rational use of medicines).	**III** Actions aimed at minimizing functional impairment arising from an acute or chronic health problem and reducing the impact and prevalence of a chronic health condition in an individual or in society. (Example: preventing diabetic complications).

Social determinants are a major field of public-health practice. They are crucial because they are the key factors in preventing health inequalities and substantially shape public-health interventions (WHO, 2025b). The social determinants of health are:

- Income and social security
- Education
- Unemployment and job insecurity
- Working conditions
- Food insecurity
- Housing, basic amenities, and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Conflicts
- Adequate access to health services of sufficient quality

Role of Local Governments in Health Practices

The health-related duties of municipalities are broadly defined, both directly and indirectly, in Law No. 5216 on Metropolitan Municipalities and Law No. 5393 on Municipalities (Law No. 5216, 2025; Law No. 5393, 2025). Municipal legislation assigns responsibilities in supporting the construction and maintenance of health facilities and in many other areas closely related to health. In summary, these areas include:

a. Disasters and emergencies
b. Addictions
c. Communicable diseases, immunization, and epidemics
d. Noncommunicable diseases
e. Environmental health
f. Health of disadvantaged individuals
g. Epidemiology
h. Occupational health and safety
i. Accidents
j. Mental health
k. Zoonotic and vector-borne diseases
l. Other situations

Municipalities may open and operate health facilities in accordance with the law, providing fixed or mobile health services. They play an active role in preventing water, air, noise, and soil pollution. They can plan and implement scientific research and projects in the field of health. They act as stakeholders in disaster management and in the management of communicable and noncommunicable diseases. They deliver services through policies that prioritize disadvantaged groups to reduce health inequalities. In health-related matters, they cooperate with international organizations, national public bodies, private institutions and organizations, and civil-society organizations.

PURPOSE

Throughout human history, living environments have evolved from caves to villages, towns, cities, and metropolises. Today, the rapid concentration of population in cities creates new pressures across environmental, economic, and social dimensions. These pressures give rise to significant areas of debate and development in the governance of cities and the sustainability of social life. Within this context, the One Health approach offers a guiding framework for cities to develop more resilient, inclusive, and sustainable policies by addressing the environment, animals, and humans as an inclusive and ethically coherent whole.

Local governments are the key actors through which this holistic understanding of health finds concrete expression on the ground. Within the duties defined by legislation, municipalities both provide direct health services and assume responsibility across a wide spectrum of areas that affect public health–from disasters to infectious diseases, from environmental health to support for disadvantaged groups. Therefore, inclusive and sustainable policies to be developed at the local level play a critical role in protecting and protecting and enhancing public health.

Prepared by the İzmir Planning Agency (İZPA), this book constitutes the fourth volume of the Good Practices Guide Series. Throughout the series, the One Health approach has been taken as the foundation, and human health has been assessed holistically in relation to the environment and society. The first volume shared good examples for healthy cities at the global scale, the second addressed the principles of accessibility and inclusivity in disability-friendly cities, and the third highlighted practices for age-friendly cities. The present volume focuses specifically on local governments' practices in the field of health and compiles global and local good practice examples that municipalities can utilize in fulfilling their responsibilities toward public health.

The provision of health services requires all institutions and organizations operating at the national and international levels (public, private, civil society, etc.) to work in a multisectoral manner. Because institutions' physical, financial, and human resources are limited, health services are implemented through these collaborations. In these collaborations, the foremost duty of local governments is to draw on scientific evidence, undertake urban planning, and provide the necessary social services to ensure that the city can be healthy. The purpose of this book is to share good practice examples that local governments can benefit from in healthy city planning and to support the local implementation and dissemination of these examples.

METHODOLOGY

This study, prepared for the Department of Health Affairs of the İzmir Metropolitan Municipality, presents an assessment of good practice examples directly linked to the United Nations Sustainable Development Goals (SDGs) under the One Health umbrella. Based on this assessment, a thematic list has emerged. The screening and evaluation process is shown as follows.

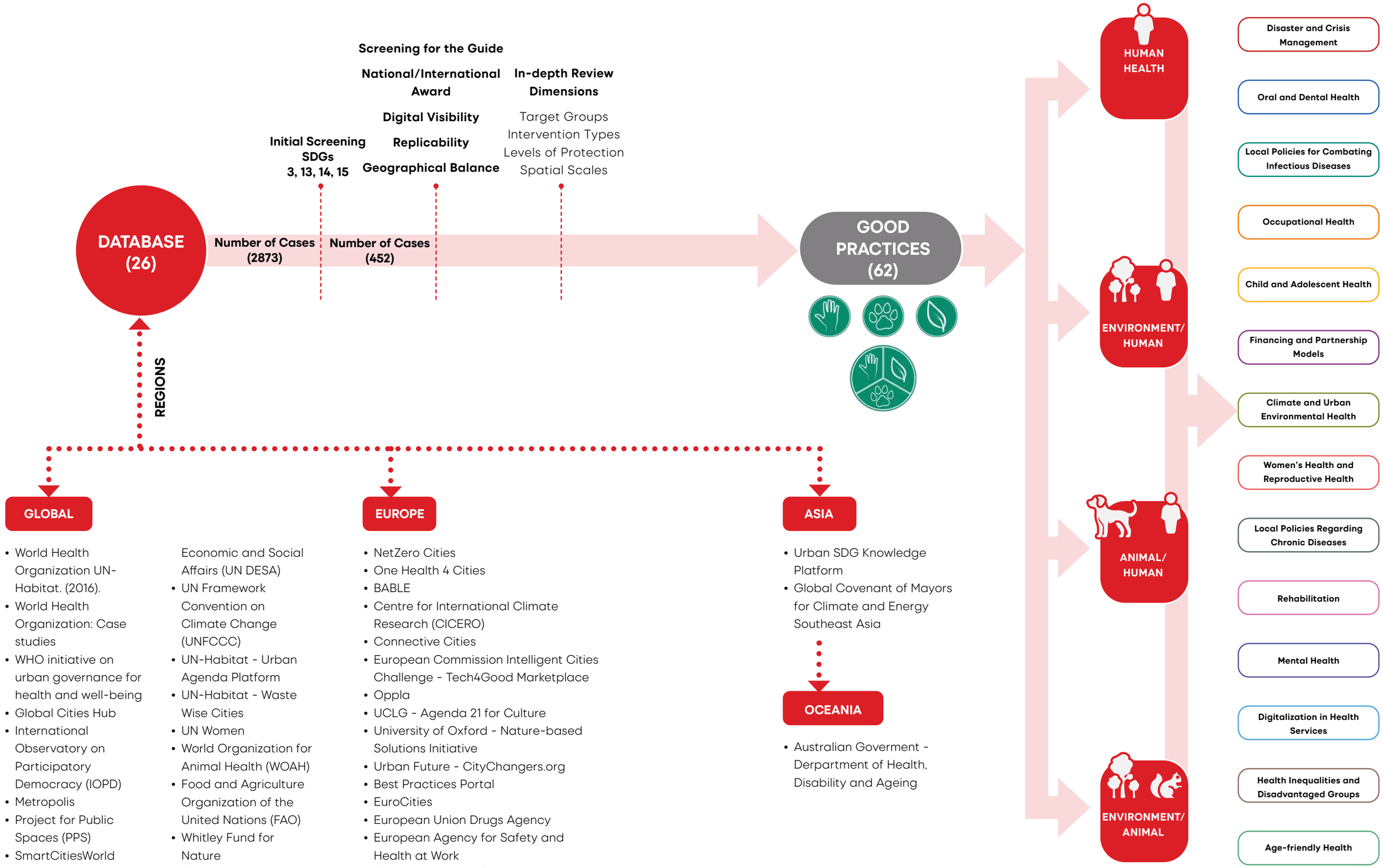
1. Listing of Databases

In line with the year the SDGs emerged in the literature, the research team reviewed different sources (databases) that were announced, and published good practice examples implemented after 2015. The following criteria guided the database scanning process:

- In addition to providing solutions to various SDGs, good practice examples should serve as guidance for implementation and should not be produced solely at the conceptual level as policy and strategic documents.
- Data sources should present systematic listings and include examples on a global geographic scale.
- Projects not yet been implemented and remain at the data collection and observation stage were excluded.
- Sources that contain only news or articles and do not include good practice examples were excluded.
- To avoid duplication, sources using the same datasets were identified and such overlapping examples were excluded.

This study scanned and used the databases for health applications, as shown in Table 1. These databases yielded **2,873 good practice examples.**

Figure 1. Good Practice Selection System and Related Databases



- World Health Organization UN-Habitat. (2016).
- World Health Organization: Case studies
- WHO initiative on urban governance for health and well-being
- Global Cities Hub
- International Observatory on Participatory Democracy (IOPD)
- Metropolis
- Project for Public Spaces (PPS)
- SmartCitiesWorld
- UN Department of Economic and Social Affairs (UN DESA)
- UN Framework Convention on Climate Change (UNFCCC)
- UN-Habitat - Urban Agenda Platform
- UN-Habitat - Waste Wise Cities
- UN Women
- World Organization for Animal Health (WOAH)
- Food and Agriculture Organization of the United Nations (FAO)
- Whitley Fund for Nature
- Gender & Health Hub

- NetZero Cities
- One Health 4 Cities
- BABLE
- Centre for International Climate Research (CICERO)
- Connective Cities
- European Commission Intelligent Cities Challenge - Tech4Good Marketplace
- Oppla
- UCLG - Agenda 21 for Culture
- University of Oxford - Nature-based Solutions Initiative
- Urban Future - CityChangers.org
- Best Practices Portal
- EuroCities
- European Union Drugs Agency
- European Agency for Safety and Health at Work
- The Innovations in Politics Institute

- Urban SDG Knowledge Platform
- Global Covenant of Mayors for Climate and Energy Southeast Asia

- Australian Goverment - Derpartment of Health, Disability and Ageing

Table 1. Databases Reviewed

	Database	Link
1	World Health Organization & UN-Habitat. (2016) . Global report on urban health: equitable healthier cities for sustainable development. World Health Organization.	https://iris.who.int/handle/10665/204715
2	World Health Organization: Case studies: cities and urban health	https://www.who.int/teams/social-determinants-of-health/urban-health/cities-and-urban-health
3	WHO initiative on urban governance for health and well-being	https://www.who.int/initiatives/urban-governance-for-health-and-well-being
4	NetZero Cities	https://netzerocities.app/
5	One Health 4 Cities	https://urbact.eu/networks/one-health-4-cities
6	BABLE	https://www.bable-smartcities.eu/explore
7	C40	https://www.c40.org/case-studies/
8	Centre for International Climate Research (CICERO)	https://www.cicero.oslo.no/en/projects
9	Connective Cities	https://www.connective-cities.net/en/good-practices
10	European Commission Intelligent Cities Challenge - Tech4Good Marketplace	https://marketplace.intelligentcitieschallenge.eu/en
11	Global Cities Hub	https://globalcitieshub.org/en/good-urban-practices/
12	Global Covenant of Mayors for Climate and Energy Southeast Asia	https://www.asean-mayors.eu/best-practices/
13	International Observatory on Participatory Democracy	https://oidp.net/en/practices.php
14	Metropolis	https://use.metropolis.org/case-studies
15	Oppla	https://oppla.eu/case-study-finder
16	Project for Public Spaces (PPS)	https://www.pps.org/projects
17	SmartCitiesWorld	https://www.smartcitiesworld.net/
18	UCLG - Agenda 21 for Culture	https://obs.agenda21culture.net/en/home-grid

Table 1. Databases Reviewed

	Database	Link
19	UN Department of Economic and Social Affairs (UN DESA)	https://sdgs.un.org/partnerships/browse
20	UN Framework Convention on Climate Change (UNFCCC)	https://www4.unfccc.int/sites/NWPStaging/Pages/Search.aspx
21	UN-Habitat - Urban Agenda Platform	https://www.urbanagendaplatform.org/best-practice
22	UN-Habitat - Waste Wise Cities	https://unhabitat.org/waste-wise-good-practices
23	University of Oxford - Nature-based Solutions Initiative	https://casestudies.naturebasedsolutionsinitiative.org/case-search/
24	Urban Future - CityChangers.org	https://citychangers.org/
25	Urban SDG Knowledge Platform	https://www.urbansdgplatform.org/csd/csd.msc;jsessionid=A5DA3EB7ED06FE637CC8FC6B2297E4FB
26	Best Practices Portal	https://webgate.ec.europa.eu/dyna/bp-portal/submission/search
27	Gender & Health Hub	https://www.genderhealthhub.org/
28	EuroCities	https://eurocities.eu/awards/
29	European Union Drugs Agency	https://www.euda.europa.eu/best-practice_en
30	European Agency for Safety and Health at Work	https://osha.europa.eu/en
31	Avustralya Hükümeti - Sağlık, Engellilik ve Yaşlanma Bakanlığı	https://www.health.gov.au/
31	UN Women	https://www.unwomen.org/en
32	The İnnovations in Politics İnstitute	https://innovationinpolitics.eu/
33	World Organization for Animal Health	https://www.woah.org/en/home/
34	Food and Agriculture Organization of the United Nations	https://www.fao.org/home/en
35	Whitley Fund for Nature	https://whitleyaward.org/awards/

2. Initial Screening Process

In the initial screening process, the research team selected the projects that includes one or more of **SDG 3** (Good Health and Well-Being), **SDG 14** (Life Below Water), and **SDG 15** (Life on Land), which are directly associated with the overarching **One Health theme**, and that intersected with **SDG 13** (Climate Action). In addition, the prepared Good Practices Guide is structured aroundcity examples worldwide. Therefore, the research team selected cases reflecting well-being in urban life from sources related to SDG 11 (Sustainable Cities and Communities), even though this goal is not directly linked to the One Health theme.

As a result of this initial screening, the team selected **452 good practice examples.**

3. Selection Criteria for the Guide

Four main criteria shaped the final screening of these good practice examples:

- **Awards:** Projects that received awards on national or international platforms or were recognized as a good practice by the UN and/or its component organizations
- **Digital Visibility:** High visibility of projects in the digital domain
- **Replicability:** The potential to be replicated across different geographies and scales
- **Geographic Balance:** Geographic balance was considered to avoid selecting multiple similar examples from the same region.

Beyond these main criteria, the selection process also considered target groups, types of intervention, levels of prevention, and spatial scales as important aspects. There was a special focus on primary and preventive approaches within the levels of prevention. In this way, the selected examples reflect the different scales of responsibility of local governments and the multidimensional intervention areas in the field of health. At the end of this screening process, 62 good practice examples emerged as prominent and were selected for the book.

4. Densities of One Health Categories and Meta-Keyword Categorization

Before their inclusion in the guide, the good practice examples underwent a density assessment according to the categories of the overarching One Health theme (human, animal, and environment). Table 1 shows the resulting distribution of examples.

Table 2. Distributions of examples by the One Health theme

	Heading	Share of Total Examples
1	Human Health	%75
2	Environmental Health and Human Health	%15
3	Animal and Environmental Health	%2
4	Animal Health and Human Health	%2
5	Human, Environmental and Animal Health	%6

However, local governments largely shape their health-related responsibilities around human health and its environmental and social determinants. They mostly address the issues related to environmental and animal health together with human health. For example, environmental health comes to the fore in the areas of water, air, and climate, while animal health is highlighted in connection with human health within the frameworks of zoonotic diseases or food safety.

For this reason, the guide does not include examples focusing solely on environmental health or solely on animal health and the table's distribution accordingly does not reflect them.

Table 3. Distributions of examples by inclusive keywords

	Inclusive Keyword	Share of Total Examples
1	Disaster and crisis management	%6,4
2	Oral and dental health	%4,3
3	Local policies for combating infectious diseases	%8,5
4	Occupational health	%10,5
5	Child and adolescent health	%6,4
6	Financing and partnership models	%2,1
7	Climate and urban environmental health	%12,8
8	Women's health and reproductive health	%8,5
9	Local policies regarding chronic diseases	%8,5
10	Rehabilitation	%4,3
11	Mental health	%8,5
12	Digitalization in health services	%4,3
13	Health inequalities and disadvantaged groups	%10,6
14	Age-friendly health	%4,3

In addition, 14 inclusive keywords guided the categorization and the proportion of the examples (local policies for combating infectious diseases, local policies regarding chronic diseases, oral and dental health, mental health, women's health and reproductive health, occupational health, health inequalities and disadvantaged groups, digitalization in health services, age-friendly health, child and adolescent health, disaster and crisis organization, financing and cooperation models, climate and urban environmental health, rehabilitation). The number of examples included in the guide was designated according to their percentage weights as shown in the Table 2.. Finally, the guide features **50 good practice examples** to provide the necessary level of detail and to facilitate readers' follow-up. In addition, an online version of the guide includes the 62 examples, accessible to readers.

Readers can find the online database link here:

INCLUSIVE KEYWORDS

The good practices included in this guide are grouped around inclusive keywords to make visible the contributions and impacts that cities produce for individuals and to enhance readability. İn this section, concise and focused definitions are provided for each keyword to clarify the conceptual framework within which both the examples in the guide and the shared database are situated. The aim is to convey, in comparable terms, how the projects contribute to individuals' quality of life and develop solutions. Although the headings are presented under separate categories, many practices are assessed in complementary or intersecting dimensions. The Climate and Urban Environmental Health heading points not only to the reduction of environmental risks but also to dimensions of spatial regulation, social resilience, and quality of life. Similarly, the headings of Elderly Health and Health İnequalities and Disadvantaged Groups are directly related to strengthening social participation and social bonds. Therefore, each example has been matched with the areas of activity that predominantly come to the fore in project implementation, thereby providing consistent guidance for both thematic readings and needs-oriented searches.

1. Disaster and Crisis Management: Disaster and crisis management refers to a holistic framework that operates disaster risk reduction and early warning systems at the local scale while strengthening coordination among institutions. This approach clarifies the steps of preparedness, response, and recovery to increase community resilience; allocates responsibilities; and accelerates field practices through data-driven crisis management. The goal is to establish an interoperable governance structure in which risks are managed in advance and rapid decisions can be made at the moment of disaster.

2. Oral and Dental Health: Oral and dental health is addressed as an integral part of life-course health. Under this heading, strengthening preventive practices, expanding regular check-ups, and developing community-based awareness efforts gain importance. A healthy oral structure is not merely a matter of hygiene or aesthetics; it is also a critical indicator for nutrition, overall health, and the sustainability of social life.

3. Local Policies for Combating Infectious Diseases: At the local level, infectious disease policies integrate surveillance and early warning systems and make preventive health services and vaccination practices accessible at the community scale. Within the One Health approach, human, animal, and environmental data are jointly assessed, and laboratory infrastructure and reporting networks are strengthened. In this way, potential outbreaks are detected in time, chains of transmission are quickly interrupted, and community safety is protected.

4. Occupational Health: Occupational health strengthens occupational safety standards with ergonomics and risk analysis while also encompassing the management of psychosocial risks. Institutions support healthy behaviors through workplace health promotion programs, age-sensitive practices, and digital tools (training, monitoring, feedback). The result is a sustainable workplace culture that increases productivity and reduces occupational accidents.

5. Child and Adolescent Health: Child and adolescent health expands preventive services through healthy nutrition, physical activity, and school health programs. Behavioral health and obesity prevention components are carried out together with family and school networks. The aim is to secure lifelong well-being through healthy habits acquired at an early age.

6. Financing and Partnership Models: This heading secures the sustainability of health projects by using tools such as public-private partnerships, grants and funding, and social impact investment. Multi-stakeholder governance and budget support loans are tracked with performance-based indicators. Thus, limited resources are directed toward initiatives that generate measurable social benefit.

7. Climate and Urban Environmental Health: Climate and urban environmental health reduces harmful environmental exposures to health through air quality management, sustainable mobility, and green infrastructure. Urban heat island mitigation and climate adaptation planning produce just solutions that prioritize vulnerable groups. The city's planning decisions are aligned with health impact assessments.

8. Women's Health and Reproductive Health: Women's health encompasses a broad spectrum ranging from perinatal care to menstrual health and hygiene, from family planning and HPV vaccination to breastfeeding support. Services are designed to reduce gender-based barriers and are supported with protective and referral mechanisms against gender-based violence. The goal is safe and equitable health care throughout the life course.

9. Local Policies Regarding Chronic Diseases: Local policies for chronic diseases operate with integrated care pathways and risk stratification to direct resources to those with the greatest need. Policy implementation works in tandem with digital monitoring, lifestyle interventions, and community-based prevention programs. Data-oriented tracking reduces complications while strengthening continuity of care.

10. Rehabilitation: Rehabilitation aims to strengthen individual independence through community-based and multidisciplinary approaches. Early intervention and assistive technologies increase participation in daily life, while accessible design in housing and public spaces ensures that this process yields lasting and sustainable results.

11. Mental Health: Mental health is made accessible through community-based centers, early screening mechanisms, and psychosocial support services. Crisis intervention protocols and anti-stigma efforts are carried out in integration with primary care. The goal is to lower barriers to help-seeking and make recovery durable through social support.

12. Digitalization in Health Services: Digitalization securely brings together electronic health records, remote monitoring and telemedicine applications, AI-supported decision-making, and data integration. Cybersecurity and ethical frameworks protect personal data while improving the quality of care. The result is equitable and measurable health services, independent of time and place.

13. Health Inequalities and Disadvantaged Groups: This heading places principles of access and inclusivity at the center to produce policies that target social determinants. Culturally safe services are carried out with a gender and justice perspective and with community participation. Mobile teams, field-based counseling, and translation/interpretation support reduce invisible barriers.

14. Age-Friendly Health: Age-Friendly health, guided by the vision of healthy aging, covers frailty prevention, home care, support services, and dementia-friendly communities. Active living and social participation reduce loneliness and isolation. Services in this field are strengthened through support for caregivers and accessible spatial arrangements.

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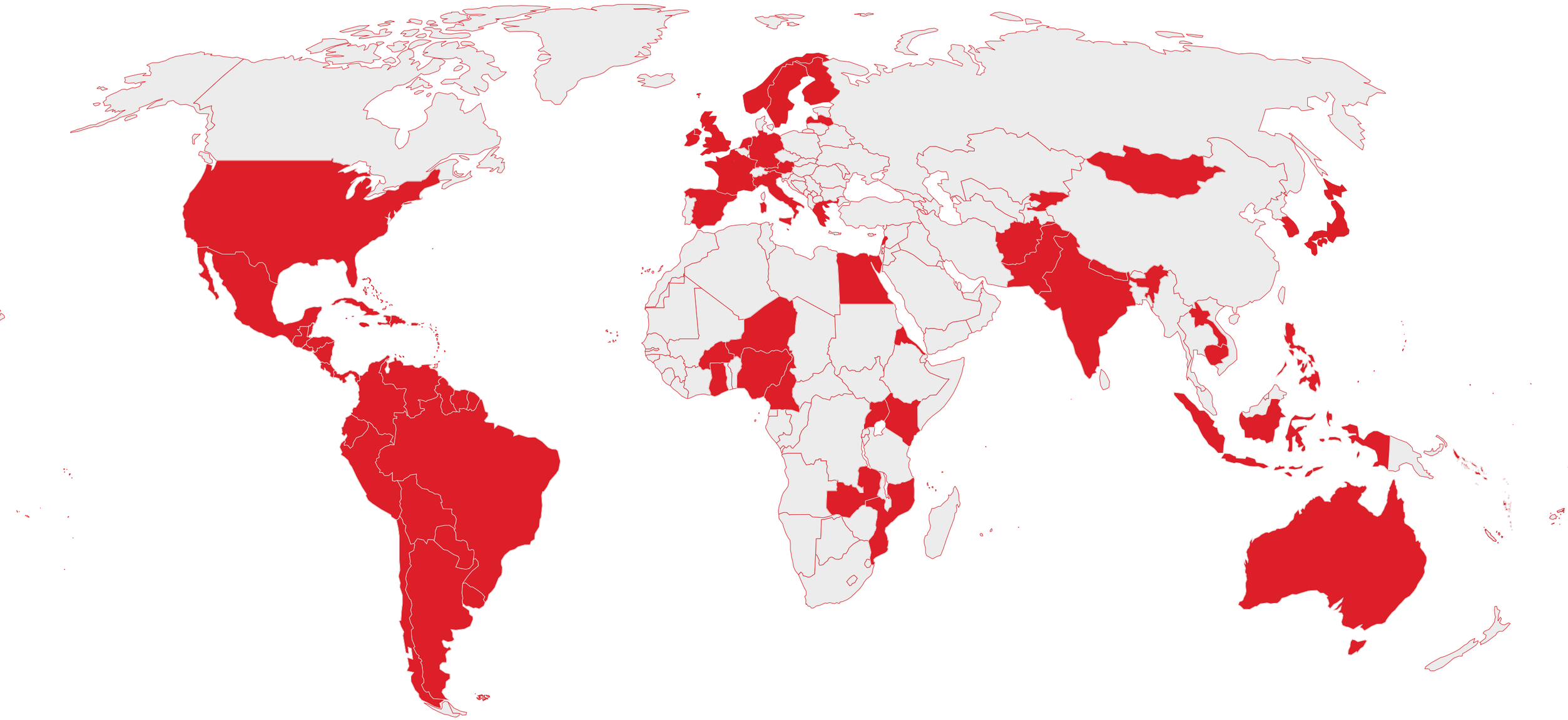
READING THE GUIDE

GEOGRAPHICAL DISTRIBUTION OF GOOD PRACTICES

The geographical distribution of the examples is as shown on the map.



GLOBAL GOOD PRACTICES

MULTI-AGENCY RISK ASSESSMENT CONFERENCES

LOCATION: Cardiff, South Wales, United Kingdom

DATE: 2003-2014

Domestic Violence | Interagency Cooperation | Risk Assessment

PROJECT TITLE — Multi-agency risk assessment conferences

TARGET GROUP — Victims of domestic violence and intimate partner violence

PREVENTION LEVELS — Secondary and Tertiary Prevention

Multi-Agency Risk Assessment Conferences (MARACs) were launched in 2003 in Cardiff, Wales, to enhance the safety of domestic violence and intimate partner violence victims, prevent repeat victimization, and strengthen interagency cooperation across the United Kingdom. The model originated from the finding that high risk violence cases cannot be resolved through the intervention of a single institution, the coordinated and swift action of different actors plays a critical role in protecting both the victim and society.

In the system's operation, high risk cases are referred to MARAC meetings by the police or social services. The main criteria for referral are high scores on standardized risk assessment tools, the emergence of serious concerns about the victim's safety, or the recurrence of cases within a 12 month period. These meetings last half a day and proceed through 15-20 cases each. Every institution shares only critical information related to the specific case, thus preserving both confidentiality and effectiveness. Subsequently, action plans are prepared to protect the victim and manage the perpetrator's risks, containing feasible, short term measures with clearly assigned responsibilities.

Participation in MARAC meetings spans a wide spectrum. Police, prosecutors, probation services, child protection and health services, housing authorities, Independent Domestic Violence Advisors (IDVAs), and relevant civil society organizations take part in the process. Collaboration among these actors not only protects the victim, it also creates a multidimensional platform for intervention in terms of child safety, housing rights, access to health services, the perpetrator's legal processes, and public safety. At the center of the model, IDVAs bring the victim's voice to the meeting, monitor the process, and follow up on the implementation of plans.

Launched in 2003, the model had, by 2014, scaled nationally with the establishment of more than 280 MARAC units across the United Kingdom. Through its direct intersections with health services, child policies, housing regulations, and the criminal justice system, MARAC has become an integral part of integrated public policy. The conferences are administered by a government supported charity, SafeLives, and funding is primarily provided by the Home Office. In 2014/15, the budget allocated for coordination and quality assurance reached £3.3 million.

Impact assessments of the conferences demonstrate the success of the model. Reviews conducted in Wales in 2004 and 2005, and on behalf of the Home Office in 2011, showed a marked increase in victim safety. Studies in Cardiff reported that 60% of victims stated that violence had ceased completely within six months, and 40% remained free from violence after one year. These gains were not limited to individual safety, they also contributed to a decrease in health problems and improved access to health services for victims.

Economic analyses of the conferences are also noteworthy. According to SafeLives' 2010 report, every £1 invested in MARACs yields up to £6 in savings to public agencies on expenditures related to domestic violence. This cost effectiveness is preserved even under different scenarios. Additional analyses by the Home Office have likewise confirmed that the MARAC model constitutes a sustainable and rational investment.

Key success factors include effective information sharing, the presence of the right institutional representatives in meetings, and the strong participation of IDVAs. Moreover, thanks to sound leadership and a robust coordination system, meetings remain focused on actionable measures, elements that strengthen the model's effectiveness. Nevertheless, certain challenges have been experienced. A lack of cooperation by victims or a refusal to acknowledge the violence may impede progress. In addition, the administrative burden generated by the meetings can strain the capacities of police forces in particular.

These experiences have shown that the coordination role and implementation should be kept separate.

Today, MARACs are recognized in the United Kingdom as an integrated, victim centered, and cost effective model in combating domestic violence. The practice has enhanced victims' safety, facilitated their access to health and social services, and ensured the management of risks posed by perpetrators to society.

SOURCE: European Commission. Multi-agency risk assessment conferences (MARACs).
https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/107

LOCAL SUSTAINABLE DEVELOPMENT SOLUTIONS FOR PEOPLE, NATURE, AND RESILIENT COMMUNITIES

LOCATION: St. Mary Parish, Jamaica

DATE: 1991 - ongoing

Disaster Risk Reduction | Sustainable Agriculture | Community Resilience

PROJECT TITLE

TARGET GROUP

PREVENTION LEVELS

Local sustainable development solutions for people, nature, and resilient communities

Rural communities, women farmers, youth

Primary Prevention

The Disaster Resilience and Sustainable Agriculture Based Community Model was implemented under the leadership of the Jeffrey Town Farmers Association, founded in 1991 in the community of Jeffrey Town in Jamaica's St. Mary Parish. Initially emerging through the initiative of three farmers, this organization was born out of the need for solidarity among small producers in rural areas who were unable to make a living from traditional agricultural products and who were vulnerable to an increasing number of natural disasters. Severe tropical storms, prolonged droughts, and landslides heavily affected both the environment and the economy, triggering impoverishment and migration within the community. Under these conditions, farmers saw it as essential to develop a new community model that combined economic stability with environmental protection.

The association's core approach is to view agriculture not merely as a production activity but as the locomotive of rural development. The principal goals of the organization have been the sustainable use of local resources, the active participation of women and youth, and the enhancement of the community's resilience to disasters.

Over time, the movement evolved beyond being a mere farmer solidarity platform and transformed into a multifaceted rural development model encompassing disaster risk reduction, ecological conservation, organic production, income diversification, and youth empowerment.

Activities are grouped into five main areas. First, disaster risk reduction and climate adaptation efforts have been carried out, terracing, gabion walls, bunds, and tree planting projects have been implemented to reduce landslide and flood risk. Measures such as making roofs hurricane resilient, installing rainwater harvesting systems, and operating a community center powered by renewable energy offer concrete solutions that enhance resilience both before and after disasters. Second, ecological farming and land restoration have been focal areas. Farmers have been trained in organic agriculture, composting, drought resistant crops, and agroforestry, pineapple, sugarcane, and fruit trees have been planted on sloped lands to prevent soil loss. Thanks to these practices, cultivated diversity across 30 decares of land has increased, ensuring food security and enabling the development of value added products for the market.

Third, income generating activities have been supported. Women have been encouraged to engage in poultry farming and small scale food processing, contributing to the local economy through products such as jams, pickles, and spices. Traditional coconut processing methods have also been revitalized. Fourth, youth participation has played an important role. Through Jeffrey Town Radio, more than fifty young people have taken part in media production and in the development of content on climate change, organic farming, and public health. In this way, young people have gained technical skills and prepared for leadership roles in the community's future. Finally, shared spaces that strengthen social solidarity have been created, community centers have served as gathering places during disasters and as training venues.

The model's impacts have been tangible across environmental, economic, and social dimensions. Landslide risk has decreased, soil fertility has increased, and thanks to ecosystem restoration, Jeffrey Town received "best environmental practices" awards in Jamaica in 2010 and 2012. Women's income generation has risen and their leadership has been strengthened, women have accounted for 60% of the association's board and 75% of its executive committees. Steering young people toward alternative livelihoods in agriculture has created solutions to structural problems such as migration and unemployment. In addition, the construction of new health and education facilities has been achieved through community advocacy.

At the policy level, the Jeffrey Town Farmers Association model has directly contributed to Jamaica's Vision 2030 National Development Plan and developed recommendations for climate change policies. It has set an example for integrating disaster risk reduction into national strategies and has transferred knowledge to other communities by participating in national and international networks. Thus, it has functioned as a laboratory for community based development not only at the scale of a single village but across the country.

Sustainability is built upon the spirit of volunteerism and the active participation of youth. Although revenues are limited, a small scale financing model has been developed through radio advertisements, use of the community center, and product sales. All income generated is reinvested in the community. The association has also become a model community by sharing knowledge with other villages and disseminating its practices at the national level.

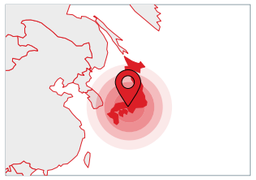
SOURCE: Equator Initiative. (2017). Local sustainable development solutions for people, nature, and resilient communities. https://www.equatorinitiative.org/wp-content/uploads/2017/05/case_1458760405.pdf

BUILDING HUMAN SOURCES TO STRENGTHEN COMMUNITY DISASTER PREVENTION

LOCATION: Matsuyama, Japan

DATE: 2005 - ongoing

Disaster Prevention Education | Community Participation | Intergenerational Learning



PROJECT TITLE

TARGET GROUP

PREVENTION LEVELS

Initiatives for developing human resources toward enhancing community disaster prevention capabilities
Children, youth, older adults, university students, company employees, and community volunteers
Primary Prevention

Due to its geographic location, Japan frequently faces devastating earthquakes, typhoons, tsunamis, and floods caused by heavy rainfall. Disasters such as the 1995 Hanshin-Awaji Earthquake, the 2004 Chuetsu Earthquake, the 2011 Great East Japan Earthquake, and the 2016 Kumamoto Earthquake have resulted in thousands of deaths and billions of dollars in economic losses. Statistics show that approximately 90% of people rescued in such disasters receive help not from professional teams but from local communities. This has revealed how critical community based preparedness and resilience capacity are in the face of disasters. In this context, the city of Matsuyama launched the “Training to Strengthen Community Disaster Resilience” program in 2005 and, through the “Bousaisi” model of training disaster prevention personnel, transformed it into an institutional structure that encompasses different segments of society. What began as a single initiative gradually evolved into a multi actor, intergenerational, and institutionally supported capacity building program. Its fundamental aim is to enhance the city’s overall preparedness for disasters, strengthen community resilience, and develop the capacity for organized action during disasters.

The program’s implementation steps are grounded in a multi-layered approach that encompasses both individual training and institutional cooperation. First, comprehensive training has been organized for Bousaisi, defined as disaster prevention personnel, and to date more than 6,200 people have received this certification. The training focuses on disaster types, early warning systems, first aid, evacuation plans, and crisis management, with regular drills ensuring that theoretical knowledge is transformed into practical skills. Through cooperation with universities and high schools, disaster awareness has been integrated into school curricula, youth have taken active roles via the “Junior Disaster Prevention Leaders Club”, and more than 300 students have been trained as volunteer disaster leaders. Special sessions have been organized for older adults, drawing on their experience and supporting intergenerational knowledge transfer.

A distinctive innovation introduced by this program is the involvement of the private sector. The Matsuyama City Government has introduced a “Disaster Prevention Institution” certification system through which companies certify their employees for disaster prevention training. Today, more than 300 companies hold this certification, making the model the first of its kind in Japan. In addition, the “Bousai Leaders Training Center” has been established in cooperation with Ehime University and the University of Tokyo, where more than 1,000 university students have received leadership training. This center has enabled students to carry out volunteer activities both within the city and in disaster affected areas. In this way, the program differentiates itself from standard school or community trainings by combining continuous learning, volunteerism, and field experience.

In terms of financing and support, the project has received contributions from national and local governments as well as from universities and community organizations. The total project budget is approximately JPY 34 million (USD 310,500), and the resources allocated solely to the Bousaisi Program amount to JPY 5.2 million. The national government contributed JPY 7.5 million and the prefectural government JPY 2 million. Moreover, during the COVID-19 pandemic, face to face trainings were continued via online videos, ensuring uninterrupted learning. This financial and institutional diversity is an important element reinforcing the project’s sustainability.

The project has produced concrete and measurable gains. In 2018, while severe rainfall across Japan caused the deaths of 200 people, no loss of life occurred in Matsuyama’s Takahama area thanks to early evacuation warnings by Bousaisi volunteers. This directly demonstrates the program’s effectiveness. In addition, the city of Matsuyama has won the Cabinet Office Disaster Prevention Achievement Award four times in the past five years and has received three prestigious national awards: the Fire and Disaster Management Agency Commissioner’s Award, the Japan Resilience Award Semi Grand Prix, and the Disaster Prevention National Competition Grand Prize. These awards show that the program serves as an exemplary model not only locally but also nationally.

Among the program’s other achievements are reduced disaster response times at the community level, increased sense of trust within the community, and strengthened capacity for organized action among individuals. Thanks to the intergenerational training approach, young people have taken on volunteer roles, older adults have contributed through experience transfer, and a culture of solidarity has been reinforced. The program’s flexible and localizable structure facilitates its applicability in smaller cities and in regions with different risk profiles. Future plans include expanding disaster prevention trainings to more areas and sharing knowledge internationally.

SOURCE: Urban SDG Knowledge Platform. Initiatives for developing human resources toward enhancing community disaster prevention capabilities.
https://osha.europa.eu/sites/default/files/hwc-20-22-good-practice-booklet-en.pdfhttps://www.urbansdgplatform.org/profile/profile_caseView_detail.msc?no_case=526

DENTISTRY AND REFORESTATION

LOCATION: Borneo, Indonesia
DATE: 2007 - ongoing

Community Health | Forest Conservation | Integration

PROJECT TITLE — Dentistry and Reforestation, Borneo
TARGET GROUP — Local people, rural communities
PREVENTION LEVELS — Primary Prevention

Gunung Palung National Park in Indonesia's West Kalimantan region is one of the world's most important rainforest habitats and is home to approximately 10% of the global orangutan population. However, this biological richness has been under serious threat in recent years due to rapidly increasing deforestation. Difficulties experienced by local communities in accessing health services have pushed individuals toward illegal logging. This has negatively affected both the forest ecosystem and livelihoods. People have often had to sell timber to meet urgent health expenses, accelerating ecosystem degradation. This contradiction created a situation that required simultaneous solutions to both health and environmental problems.

In this context, the Dentistry and Reforestation project, launched in 2007 by Dr. Hotlin Ompusunggu and her team, developed an integrated strategy that placed community health and environmental sustainability at its center as a singular initiative. The aim of the project is to eliminate the need to damage the forest in order to meet local people's health needs and to support communities in building lives that are both healthier and ecologically responsible. For this reason, the project not only provided individual treatments but also developed an innovative payment model aimed at transforming social behaviors.

In its implementation steps, the project established an integrated system that both expanded health services and encouraged environmental conservation. First, through fixed clinics and mobile health teams, basic and dental health services were delivered to approximately 24,000 people. These clinics provided not only dental treatment but also child health, immunization, and basic medical needs. However, the true innovation emerged in the way these services were financed. When members of local communities pledged to protect the forest, they were able to benefit from health services with discounts of up to 70%. In addition, they could pay not in cash but through tree planting, organic farming practices, or volunteer labor. In this way, individuals were encouraged to participate directly in conservation activities rather than damaging the forest.

Unlike standard health service practices, this model brought together environmental responsibility and social benefit. The project's localizability is evident in its design tailored to the region's needs. For example, the primary driver of deforestation in the area, illegal logging, is directly linked to health expenses, therefore, the solution was placed precisely at the intersection of these two domains. The program was also strengthened through community based volunteer networks. Volunteers called "Forest Guardians" monitor illegal logging, collaborate with national park authorities, and raise awareness in communities.

From a financing perspective, the project has received significant international support. The initiative won a Whitley Award in 2011 and, by winning the Whitley Gold Award in 2016, secured a £50,000 grant. This funding was used to expand clinical services, accelerate reforestation activities, and scale up educational efforts. In addition, with further support provided in 2019, the project began to be adapted for the Batang Toru Forest in Sumatra, the habitat of the Tapanuli orangutans, of which only 800 individuals remain.

The project's impacts reached a measurable level in a short time. According to Whitley sources, the number of households participating in illegal logging decreased from 1,350 to 450. More than 100,000 seedlings were planted as part of reforestation, and farmers were taught organic farming techniques through agroecological methods. In this way, both local food security increased and alternative sources of income were developed. Improvements were also observed in health indicators within the community, and the services provided by the clinics filled significant gaps in child health and basic medical care.

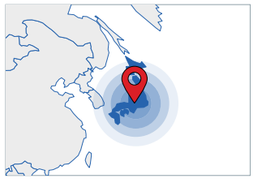
Environmentally, reforestation and the reduction of illegal logging have directly contributed to the conservation of biodiversity in the region. The project has not only protected the forest ecosystem but also strengthened the sustainability of orangutan habitats. On the social side, the establishment of volunteer networks has increased solidarity within the community and enabled individuals to see themselves not only as recipients of health services but also as actors protecting nature.

SOURCE: Whitley Fund for Nature. (2016). Dentistry and reforestation, Borneo. https://whitleyaward.org/winners/dentistry-deforestation-borneo/

PROMOTING ORAL HEALTH FOR HEALTHY AGEING

LOCATION: Japan
DATE: 1989 - ongoing

Oral and Dental Health | Healthy Ageing | Preventive Health Services



PROJECT TITLE — Promoting oral health as essential to healthy ageing
TARGET GROUP — Older population
PREVENTION LEVELS — Primary Prevention

As one of the fastest ageing societies in the world, Japan has developed innovative programs to preserve the health and quality of life of its older population, with oral and dental health at the center of these efforts. Research shows that oral health is not merely a matter of hygiene or aesthetics, it plays a critical role in older individuals' nutritional status, social relationships, and capacity for independent living. Inadequate oral health is closely linked to malnutrition, risk of falls, frailty, and cognitive decline. This awareness has made oral health an integral component of healthy ageing.

Within this framework, the "8020 Campaign", launched in 1989 by the Japanese Ministry of Health and Welfare and the Japan Dental Association, became a symbol of the country's ageing policies. The campaign's goal is for individuals to retain at least 20 natural teeth by the time they reach the age of 80. A national survey conducted in 1987 found that people aged 80 had an average of five teeth, a striking finding that led oral health to take a central place in ageing health policies. Thus, the project began as a singular campaign and over time transformed into an institutionalized, ongoing policy instrument at the national level.

The Implementation of the campaign has been made possible by aligning national policy goals with local municipal services. Through municipalities, periodic dental screenings began to be carried out for individuals from middle age onward, campaigns were developed for the early diagnosis of periodontal diseases, and at-risk groups were regularly monitored. The connection between oral dryness and chewing difficulties in older adults and issues such as falls, malnutrition, and cognitive decline was particularly emphasized and integrated into multidisciplinary care programs. Thus, dentists, family physicians, nurses, and care staff became parts of the same holistic health chain.

Within the campaign, a wide set of tools has been used in practice. Nationwide awareness campaigns have been conducted, dental health education has been provided in schools, and free or low cost screenings have been offered in municipalities. In addition, oral hygiene in nursing homes has become a standard part of daily care. Training for health professionals has emphasized that oral health falls within the shared area of responsibility not only of dentists but of all health personnel. This approach has integrated oral health into the health system as a whole.

The innovative aspect of the program is that it directly links oral health with healthy ageing objectives. The relationship between problems such as aspiration pneumonia and malnutrition and oral health has been taken into account in policy design. This approach has made oral health a central indicator of both individual well-being and public health.

The program's financing structure is provided by the central government's health budget and by local government resources. By covering a significant portion of dental health services under national health insurance, access has been facilitated, and free or low cost check-up programs have been implemented especially for low income older adults. In workforce planning, dentists and dental hygienists have been supported as a priority area, and oral health personnel have become more visible in nursing homes and community based services.

The program's outcomes have yielded concrete and measurable gains. In a national survey conducted in 2016, more than 50% of individuals aged 80 were found to have more than 20 natural teeth. This transformation indicates the success of the 8020 target and shows that oral health in Japan not only prevents tooth loss but also leads to improvements in overall health indicators. Alongside improved oral health, increases have been observed in the capacity for independent living among the older population, improvements in dietary quality, and reductions in health care costs.

Indirect benefits such as reductions in life threatening risks like aspiration pneumonia and the preservation of cognitive functions are strongly emphasized in the literature. In public perception, oral health has begun to be regarded not merely as an element of aesthetics but as a critical investment in lifelong health.

Today, the program to promote oral health as essential to healthy ageing has placed oral health at the center of Japan's national ageing policies and has become a globally cited model.

The success of the 8020 Campaign has created long term effects that improve the quality of life of the older population and reduce health expenditures, in alignment with the UN Decade of Healthy Ageing (2021-2030).

SOURCE: World Health Organization (WHO). (2022). Promoting oral health as essential to healthy ageing. https://www.who.int/publications/i/item/9789240061484

NATIONAL INTEGRATED SURVEILLANCE AND RESPONSE PLAN FOR WEST NILE AND USUTU VIRUSES

LOCATION: Italy

DATE: 2008 - ongoing

Arbovirus Surveillance | Vector Control | Early Warning System

PROJECT TITLE

TARGET GROUP

PREVENTION LEVELS

National integrated surveillance and response plan for WNV and Usutu virus

General population, blood and organ donors, communities living in high risk areas

Secondary and Tertiary Prevention

Italy is one of the countries in Europe where circulation of West Nile virus (WNV) and Usutu virus (USUV) is most intense. The first human WNV cases were identified in 2008, after which the Ministry of Health launched a mandatory national integration plan in 2010. The aim of this plan, in addition to protecting human health, is to detect zoonotic viruses in birds, horses, and mosquitoes at an early stage, ensure safety in blood and organ transplantation, and prevent spread that poses risks to society.

In addition to WNV, USUV, detected especially in birds and mosquitoes, was included within the scope of surveillance, thereby establishing a unified surveillance system under one umbrella for two different arboviruses. This approach is recognized as one of the strong European examples of the One Health model that jointly considers human, animal, and environmental health.

The integrated plan is built on three main components: surveillance, laboratory capacity, and health veterinary cooperation. While the diagnosis and reporting of human cases are carried out by public health authorities, cases in birds and horses are monitored by veterinary institutions.

For vectors, especially Culex pipiens mosquitoes, specimens are regularly collected using traps, and the chain of infection is monitored through molecular analyses in laboratories.

In the field implementation of the plan, data from different disciplines are integrated. Records of bird mortality, periodic tests in sentinel chicken flocks, environmental data on mosquito abundance, and human clinical cases are all brought together in a single risk assessment mechanism. Thus, the system not only serves an early warning function but also unifies public health, veterinary, and environmental analyses within a single framework.

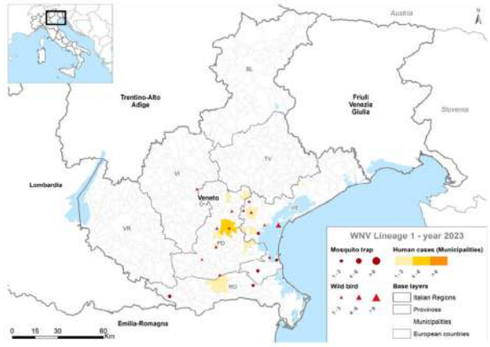
Safety in blood and organ donation has been identified as a critical area. By mandating molecular testing for all blood and organs donated in infected areas, the National Blood Centre has reduced the risk of transmission through transfusion and transplantation to nearly zero.

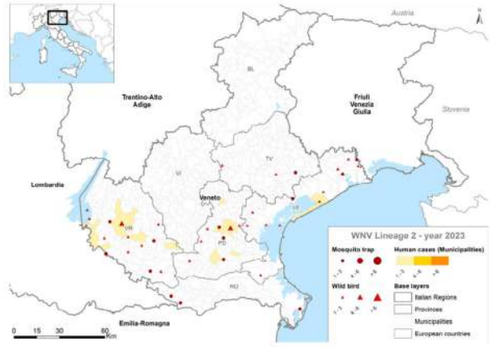
The plan's effectiveness becomes particularly apparent during periods of major outbreaks. During the large scale WNV outbreak in 2012, the risk of transmission via transfusion was controlled thanks to 100% screening of all blood donations. In 2018, when human cases increased rapidly in Northern Italy, the integrated system proved its early warning capacity. In the summer of 2022, an extraordinarily large WNV outbreak occurred in the Veneto region, with more than 500 human infections reported in this region alone. This wave was associated with the spread of WNV-2 as well as the re introduction of WNV-1 in 2021 and again revealed the system's warning capacity.

Thanks to the system, safety in blood and organ transplantation has increased, the risk of transmission via transfusion has been controlled, and the impacts of severe outbreaks on society have been reduced. In addition to human cases, the early positivity of data from sentinel animals and mosquitoes allows infections that will appear in humans to be anticipated a few weeks in advance. In this way, health authorities can take timely measures in high risk areas.

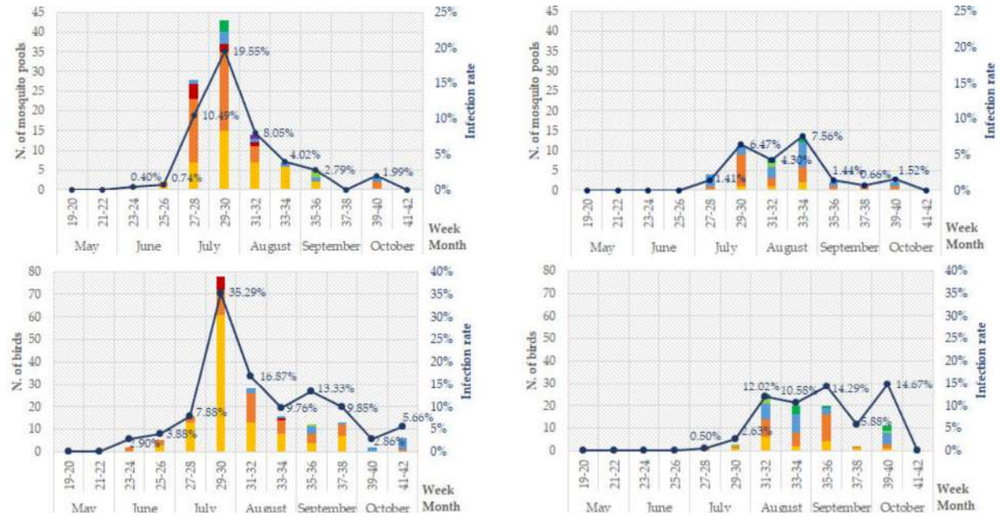
Although USUV causes human cases only very rarely, it is regularly detected in birds and mosquitoes. This shows that, beyond current threats, the system also has early warning capacity against new arbovirus risks that may emerge in the future.

The plan's financing is largely provided by the Italian Ministry of Health and the Ministry of Agriculture, with the European Centre for Disease Prevention and Control (ECDC) providing technical support. This institutional structure has led to the plan being adopted as a model not only nationally but also at the European level, and countries in the Balkans and Central Europe have begun to develop their own integrated surveillance systems inspired by Italy's experience.





In conclusion, the National Integrated Surveillance and Response Plan for WNV and Usutu virus has, since 2008, become one of the most successful examples in Europe within a One Health approach. The system has enabled early detection of zoonotic viruses, increased safety in blood and organ transplantation, and established a sustainable model for protecting public health.



SOURCES: WHO. (2019). West Nile virus (WNV) and Usutu virus surveillance: Guidance for surveillance and response.
https://iris.who.int/bitstream/handle/10665/325620/9789241514934-eng.pdf?sequence=1
Pautasso, M., Mancini, G., & Savini, G. (2022). Integrated surveillance of West Nile virus in Italy: The One Health approach. Pathogens, 11(3), 352.
https://www.mdpi.com/3199152

KENYA RIFT VALLEY FEVER STAKEHOLDER AND INSTITUTIONAL ANALYSIS

LOCATION: Kenya

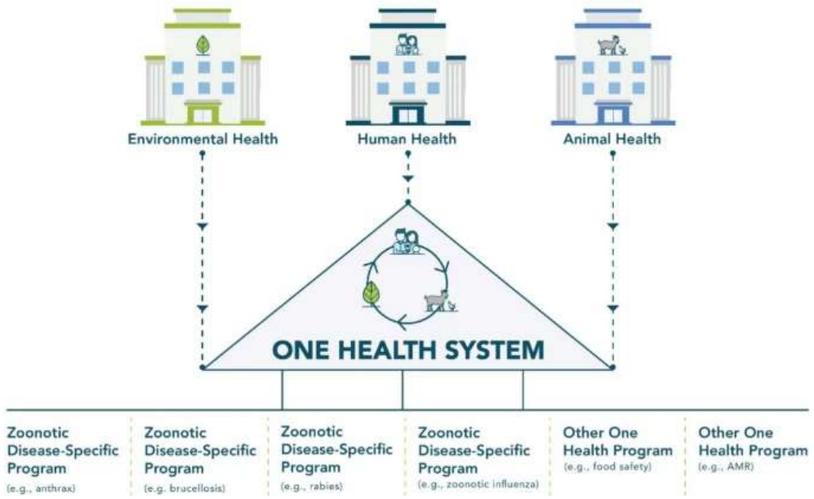
DATE: 2016 (one-off case study)

Stakeholder Mapping | Zoonotic Diseases | One Health Coordination

PROJECT TITLE
Kenya Rift Valley Fever Stakeholder and Institutional Analysis

TARGET GROUP
Human and animal health professionals, environmental authorities, policymakers

PREVENTION LEVELS
Primary Prevention



The prevention and control of zoonotic diseases requires robust cooperation among health, veterinary, and environmental institutions. However, in many countries there are communication gaps, coordination shortcomings, and capacity limitations among these institutions. A Social Network Analysis (SNA) study conducted in Kenya in 2016 aimed to map the roles and relationships of One Health stakeholders in the context of Rift Valley fever (RVF). This case provides an important example of the role of stakeholder mapping within the Generalizable One Health Framework (GOHF) in strengthening institutional coordination.

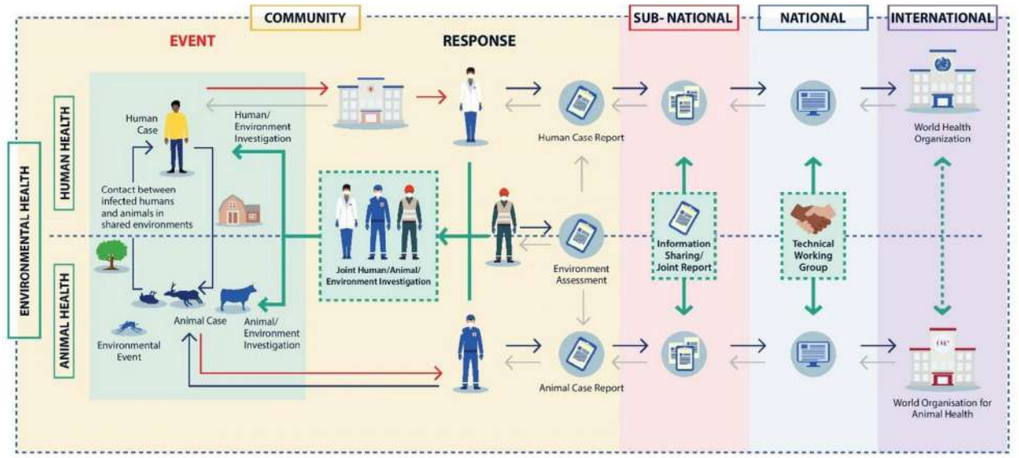
Representatives at national and regional levels from human health, animal health, and environmental institutions were included in the study, along with policymakers, local governments, and research institutions. Using the SNA method, the strength of connections among these actors, information flow, and cooperation capacities were evaluated.

The results showed that the Ministry of Health and veterinary authorities had strong ties within the network, whereas environmental institutions and local governments were represented with weaker connections. This imbalance can lead to delays in information sharing and coordination problems, especially during crises. The study revealed the critical importance of the equal inclusion of all sectors for the success of the One Health approach.

Stakeholder mapping in Kenya revealed which institutions were strong or weak in the existing network and provided insights into which institutions could assume leadership and which ones needed capacity building. The study demonstrated that mapping can be used to make invisible relationships visible within the One Health approach and to strategically steer institutional cooperation. It also produced important information on how decisions taken at the national level are implemented locally.

This analysis was presented as an example case within the Generalizable One Health Framework (GOHF), developed with contributions from international organizations such as the CDC and FAO. The Kenya example shows that stakeholder mapping is a feasible, practical, and cost effective tool, especially in low and middle income countries.

The One Health stakeholder mapping study conducted in Kenya in 2016 made inter institutional cooperation networks visible in zoonotic disease management and enabled the strategic identification of strengths and weaknesses in coordination. This example has contributed to the early detection of capacity gaps during crises, the identification of priority investment areas, and the more inclusive implementation of the One Health approach.



SOURCE: Nishijima, T., & Arai, Y. (2022). Strengthening community disaster resilience through human resource development. Scientific Reports, 12, 6191. https://www.nature.com/articles/s41598-022-12619-1

THE NATIONAL MOLECULAR SUBTYPING NETWORK FOR FOODBORNE DISEASE SURVEILLANCE

LOCATION: United States of America

DATE: 1996 - ongoing

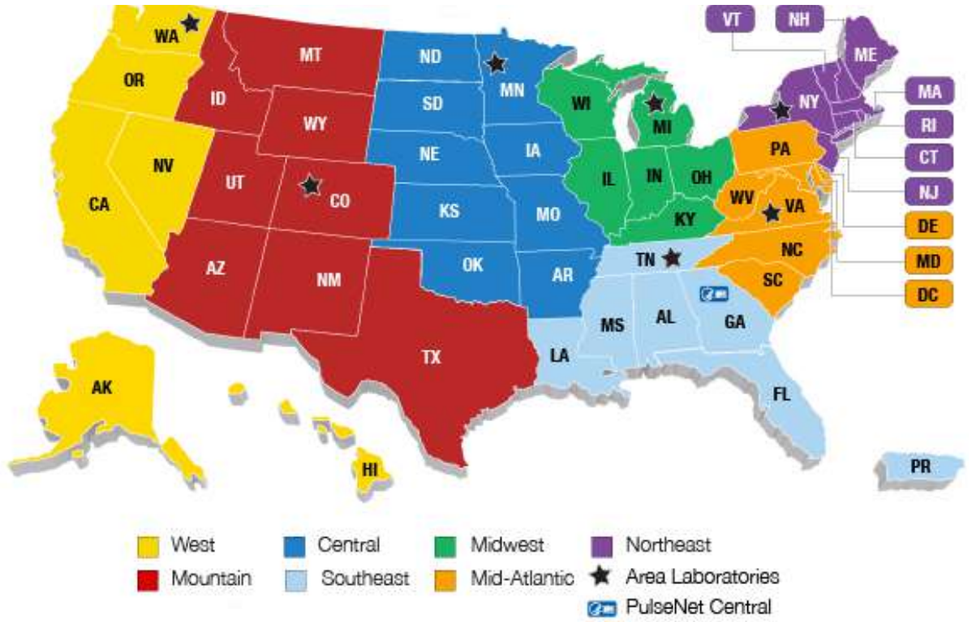
Foodborne Zoonoses | Molecular Epidemiology | Global Surveillance

PEOPLE | PEACE | PARTICIPATION | 3 GOOD HEALTH AND WELL-BEING | 17 PARTNERSHIPS FOR THE GOALS

PROJECT TITLE
PulseNet: The National Molecular Subtyping Network for Foodborne Disease Surveillance

TARGET GROUP
General population, food safety authorities, laboratories

PREVENTION LEVELS
Secondary Prevention



The PulseNet molecular surveillance system is an international laboratory network developed to enable the early detection of foodborne pathogens and the rapid control of outbreaks. Launched in 1996 by the U.S. Centers for Disease Control and Prevention (CDC), the system quickly became a national standard and was subsequently integrated into global networks with the support of the WHO, leading to implementation worldwide. PulseNet has made it possible to identify outbreaks at their source through the molecular subtyping of foodborne zoonotic pathogens, particularly Salmonella, Listeria, and E. coli O157:H7.

One of the strongest aspects of the program is the standardization of the molecular subtyping methods used by laboratories. Initially based on pulsed field gel electrophoresis (PFGE), the system has over time transitioned to whole genome sequencing (WGS) technologies. This has enabled high resolution surveillance not only at the species level but also with respect to genetic variation. Applying the same protocols across laboratories has allowed data from different countries to be compared directly and international outbreaks to be detected rapidly.

PulseNet's methodology rests on a data sharing infrastructure that connects national and regional laboratory networks on a global scale. In the United States, strong coordination has been established between local and state laboratories and the CDC, and through PulseNet International this model has spread to laboratories in Latin America, Europe, Africa, and Asia. The system has also been integrated with collaborations with the Food and Agriculture Organization (FAO) and the WHO, and supported by technical capacity building and training programs.

One of the system's innovative facets is that, alongside laboratory techniques, it institutionalizes rapid information sharing. When a pathogen's DNA profile is uploaded to the system and simultaneously made accessible to other laboratories, it becomes possible within days to determine whether cases observed in different regions derive from the same source. This mechanism has significantly strengthened the early intervention capacity of food safety authorities and public health institutions.

Funding is provided largely by the CDC in the United States. At the international level, sustainability has been ensured with support from the WHO, FAO, and regional health authorities. The European Union and other international organizations have provided funds and technical assistance to build laboratory capacity, and training programs have been conducted to enable low and middle income countries to integrate into the system.

PulseNet™ USA
The National Molecular Subtyping Network for Foodborne Disease Surveillance
CDC

With the implementation of PulseNet in the United States, the time required to detect foodborne outbreaks fell from weeks to days, and it became possible to determine rapidly whether cases observed in different states were linked to the same source.

At the international level, tracking pathogens arising from cross border food trade has likewise become easier, and a robust evidence base has been created for human health and food safety policies. For example, the large E. coli outbreak in Germany in 2011 once again underscored the importance of genomic surveillance systems and prompted the rapid development of whole genome sequencing capacity in Europe.

The system has become one of the most successful operational level examples of the One Health approach in the management of foodborne zoonoses. Through the rapid detection of pathogens that directly threaten human health, the identification of problems at their source within the animal derived food chain, and the assessment of environmental risk factors, it has generated a three pronged impact.

SOURCES: Nishijima, T., & Arai, Y. (2022). Strengthening community disaster resilience through human resource development.. Scientific Reports, 12, 6191. https://www.nature.com/articles/s41598-022-12619-1
Ribot, E. M., & Swaminathan, B. (2001). PulseNet: The national molecular subtyping network for foodborne disease surveillance in the United States. Foodborne Pathogens and Disease, 8(7), 781-784. https://pubmed.ncbi.nlm.nih.gov/11384513/

DISCOVERING ENVIRONMENTAL MANAGEMENT OPPORTUNITIES FOR INFECTIOUS DISEASE CONTROL

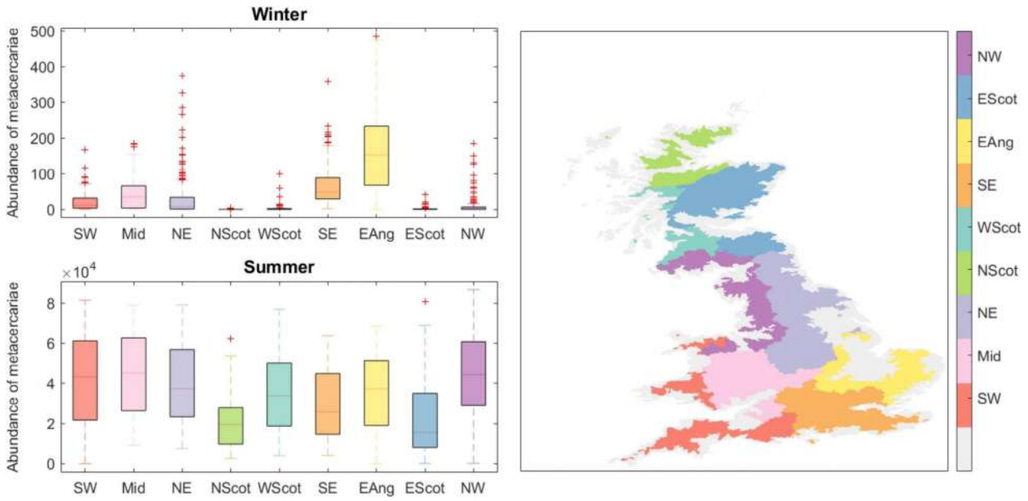
LOCATION: United Kingdom
DATE: 2006 - 2015 (Modelling Period)

Environmental Management | Fasciolosis | Climate Change

PROJECT TITLE
Discovering environmental management opportunities for infectious disease control

TARGET GROUP
Livestock, agricultural sector

PREVENTION LEVELS
Primary Prevention



Climate change, increasing drug resistance, and variability in environmental conditions make the control of many infectious diseases difficult and lead to the inadequacy of strategies based solely on drug treatment. Fasciolosis (liver fluke disease) stands out as an important parasitic disease affecting livestock and causing an annual economic loss of approximately £300 million in the UK agricultural sector. Because the habitats of intermediate host snails are sensitive to climatic and environmental conditions, this disease is closely linked to environmental factors. However, current control strategies rely almost entirely on drug treatment, which, together with increasing triclabendazole resistance, renders sustainability questionable.

The research conducted in this context aims to place the environmental dimension of the disease at the center and to show that environmental management interventions can play an alternative or complementary role to drug based strategies.

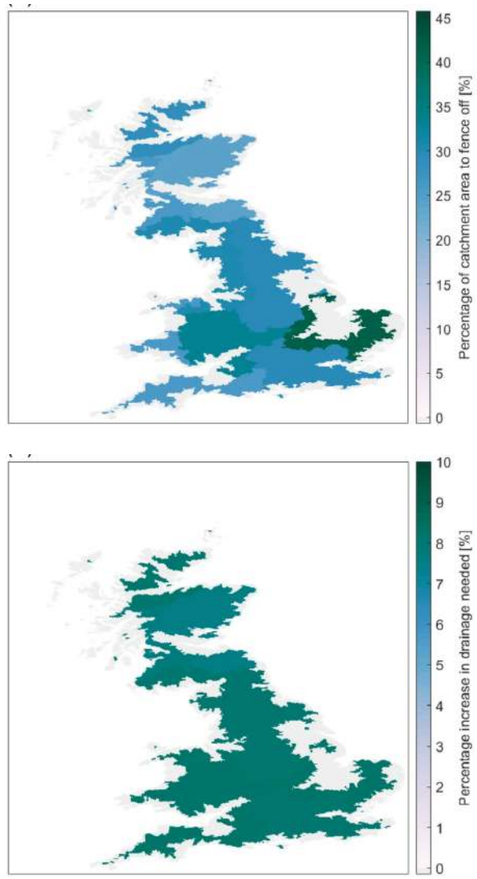
In the study, a mechanistic model called the Hydro-Epidemiological Liver Fluke Model (HELF) was developed and applied across 935 river catchments in Great Britain between 2006 and 2015. The model calculated how factors such as temperature, precipitation, soil moisture, and topography affect the habitats of intermediate host snails, thereby systematically examining the relationship between infection risk and environmental conditions. Simulations showed that rainy and mild conditions in summer increase fasciolosis risk in western England and Wales, whereas low temperatures in Scotland limit spread. In addition, it was demonstrated that regional differences in risk are strongly determined not only by climatic factors but also by topography and hydrology. This indicates that locally tailored policies at regional scale will be far more effective than single, uniform national level strategies. In particular, environmental management methods can reduce reliance on drug use, slow the rise of drug resistance, and increase farms' resilience to climate change.

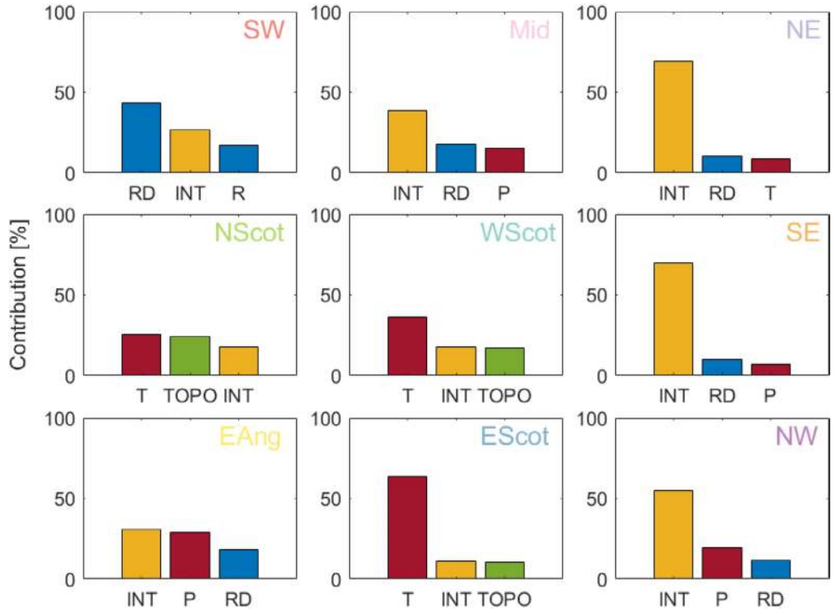
The study also evaluated the effectiveness of existing treatments. Assuming 90% efficacy for triclabendazole administered twice a year, an average 65% reduction in summer infection risk was observed.

However, it was emphasized that this effect varies by geographic region between 45% and 85% and that, due to climate change and increasing drug resistance, its long term sustainability is doubtful.

As drug free environmental management strategies, the modelling study also examined excluding livestock from high risk areas [fencing] and improving drainage. In the intervention excluding grazing from high risk areas, temporarily keeping animals away from wet and flat lands in summer provided risk reduction at levels similar to drug treatment in some regions. Effectiveness varied regionally: the proportion of area requiring fencing was calculated as 23.8% in Scotland and 42.1% in Eastern England. In the drainage improvement assessment, increasing soil drainage capacity by approximately 8% at the catchment scale produced risk reductions close to those achieved with drug treatment. However, the negative impacts of drainage on wetland ecosystems and its high cost show that this method carries policy and environmental limitations.

Although the practical feasibility of methods such as excluding livestock from high risk areas varies by region, under conditions where drug resistance is widespread and climate change accelerates the disease cycle, the importance of such environmental interventions increases. Methods like drainage are more controversial and are strategies that must be decided upon by taking into account cost and ecological impacts.





SOURCE: Nature Publishing Group. (2021). One Health approach to zoonotic diseases. Scientific Reports. https://nature.com/articles/s41598-021-85250-1?fromPaywallRec=false

WORKPLACE HEALTH PROMOTION - LOMBARDY WHP NETWORK

LOCATION: Lombardy, Italy

DATE: 2011 - ongoing

Occupational Health | Healthy Living | Corporate Social Responsibility

PROJECT TITLE
Workplace Health Promotion - Lombardy WHP Network

TARGET GROUP
Employees, employers

PREVENTION LEVELS
Primary Prevention

The prevention of chronic diseases requires not only changes in individual health behaviors but also the transformation of workplace environments. In this context, workplaces are viewed not merely as production sites but as strategic settings where health and well-being can be promoted. Launched in Italy's Lombardy region in 2011, the Workplace Health Promotion (WHP) Network is an innovative initiative that brings a holistic and institutional approach to occupational health. The program was first implemented through pilot applications in two medium sized companies in Bergamo and, following successful results, quickly scaled up to the regional level.

The main aim of the WHP is to improve the health and well-being of employees, reduce risk factors for chronic diseases, and create an organizational culture that promotes health in workplaces. This approach focuses not only on information campaigns but also on structural interventions that transform the physical and social environment of the workplace.

The most distinctive feature of the program is its accreditation system. Companies seeking to obtain the "Health Promoting Workplace" logo are required to regularly implement good practices over a three year period and to add at least four new activities each year. Areas of intervention include healthy eating, reduction of tobacco use, increasing physical activity, road safety, reduction of alcohol and substance use, and support for overall well-being.

A wide set of tools has been implemented in practice. For example, the program has introduced healthy menu options in canteens, installed healthy snacks in vending machines, used visual prompts to encourage the use of stairs, supported campaigns for cycling or walking to work, and adopted smoke free policies. In addition, partnerships have been established with sports clubs, civil society organizations, and local communities to support social interactions that go beyond workplace boundaries.

Another strong aspect of the WHP model is its multi actor structure. Employers, employees, trade unions, business associations, and local health authorities have been directly involved in the process. Thanks to this participatory approach, occupational health has not been limited to individual choices, rather, it has enabled behavioral changes and structural transformations at the organizational level.

The effects of the program were observed in a short time. Between 2013 and 2014, the number of workplaces in the network increased by 103%, and the number of employees increased by 132%. By the end of 2014, the program had reached 284 workplaces and 139,186 employees. A 12 month impact evaluation conducted in Bergamo with the participation of 94 companies and 21,000 employees revealed tangible behavioral changes, such as an increase in fruit and vegetable consumption and a decrease in smoking. These results demonstrate that workplace based health promotion interventions can be effective even in the short term.

The program has also been successful in terms of sustainability.

It has been integrated into Lombardy's Regional Prevention Plans for 2010-2013 and 2014-2018 and supported under Italy's National Prevention Plan. Thus, the WHP has gone beyond a voluntary initiative to become an institutionally adopted priority. Scientific support from local health authorities and the requirement for companies to report annually have increased the program's traceability and permanence.

The WHP Network is an important example in that it not only influences individual health behaviors but also aims to build an environment in workplaces that supports health. The program's evaluation, although non randomized, has been conducted through before/after comparative surveys and has demonstrated the effectiveness of policies aimed at occupational health.

The requirement for participating companies to continually develop good practices has also strengthened the understanding of corporate social responsibility. Moreover, the indirect spillover of workplace health into families and communities has broadened the program's societal impacts.

SOURCES: European Commission. Workplace health promotion in Lombardy. Best Practice Portal.
https://osha.europa.eu/sites/default/files/hwc-20-22-good-practice-booklet-en.pdf
CHRODIS. (2018). Adaptation and implementation of intersectoral good practices: The Lombardy program workplace health promotion (WHP Lombardy Network).
https://chrodis.eu/study-visit-adaptation-and-implementation-of-intersectoral-good-practices-the-lombardy-program-workplace-health-promotion-the-whp-lombardy-network/

PREVENTING MUSCULOSKELETAL DISORDERS

LOCATION: Vienna University Hospital (AKH Wien), Austria

DATE: 2021

Musculoskeletal Disorders | Occupational Health | Age-Friendly Workplace

PROJECT TITLE
TARGET GROUP
PREVENTION LEVELS

Preventing musculoskeletal disorders in a large hospital through staff involvement and an age-sensitive approach
Hospital employees, health professionals
Primary Prevention

Musculoskeletal disorders (MSDs) are among the most common occupational health problems in European workplaces. According to European Union data, approximately 60% of employees report back, neck, or joint pain at some point in their lives. The health sector is one of the areas where these conditions are most prevalent due to heavy workloads, manual patient transfers, and prolonged standing. Considering the ageing workforce in particular, this issue is becoming increasingly critical for both individual health and the sustainability of the health system. In this context, Austria's largest health institution, Vienna University Hospital (AKH Wien), developed an innovative strategy in 2021 to prevent musculoskeletal disorders through a comprehensive intervention. Although a singular application, the project constitutes a model that can be adapted by similar institutions in Europe thanks to its multi actor structure and age sensitive approach.

The main objective of the intervention is to reduce the physical and psychosocial workload of the 600 employees working in the hospital's Operations Department, prevent workforce losses, and protect worker health.

The average age of employees being 50 made an age sensitive approach necessary. Therefore, the project was designed not to be limited to ergonomic solutions but as a comprehensive occupational health program that takes into account the needs of different age groups.

Among the concrete implementation steps, health circles and risk management workshops were organized first. In these meetings, employees' views were gathered, risk factors were identified, and solutions were developed directly in line with their suggestions. In addition to participatory processes, trainings organized between June and December 2021 played an important role. The trainings included exercises to protect spinal health, relaxation techniques, stress management, smoking cessation support, and seminars on healthy nutrition.

Technical and ergonomic innovations also formed an important pillar of the project. More ergonomic patient transfer chairs were procured, and safety shoes and hand tools were renewed. These steps aimed to reduce the pressure on employees' backs and lower backs.

In addition, mixed-age cleaning and support teams were established. Thanks to this arrangement, younger employees undertook physically heavier tasks, while experienced employees transferred their knowledge and expertise to newcomers. Thus, workload was balanced, and a culture of intergenerational solidarity was supported.

One of the innovative aspects of the intervention is the systematic integration of the age sensitive approach into all applications. Task distribution was organized according to employees' physiological capacities, and work models suited to individual health conditions were created. This approach increased job satisfaction and enabled employees to remain in working life longer while safeguarding their health. In addition, trained health advisors were assigned within the department, and peer to peer guidance and sports activities were organized. Funding was provided largely by the hospital management. The project was integrated into occupational health and safety policies to make it sustainable and aligned with Austria's national occupational health strategies. This has enabled the project to go beyond being a corporate initiative and to serve as an example at the national level as well.

The short term effects of the project are quite striking. An increase in employees' self confidence was observed, and the roles of support staff in the hospital became more visible. Employees who had the opportunity to express their views through health circles stated that participation in decision making processes positively affected workplace culture. Thanks to mixed age teams, team solidarity was strengthened, workload was balanced, and intergenerational knowledge transfer was supported. Ergonomic equipment and arrangements alleviated employees' daily workload and reduced the pressure on the musculoskeletal system.

Although the source does not contain direct quantitative data, qualitative assessments show improvements in worker health and organizational culture. Increased employee satisfaction and the creation of a safer and healthier work environment generate important benefits for workforce continuity and the efficiency of the health system in the long term.

SOURCE: European Agency for Safety and Health at Work (EU-OSHA). (2022). Healthy Workplaces Campaign 2020-2022: Good practice booklet. https://osha.europa.eu/sites/default/files/hwc-20-22-good-practice-booklet-en.pdf

SAFE AND SUSTAINABLE DISINFECTANTS FOR PUBLIC INSTITUTIONS

LOCATION: Vienna, Austria
DATE: 1998 - ongoing

Disinfectants | Chemical Safety | Green Public Procurement

PEOPLE | PROSPERITY | PLACE

3 GOOD HEALTH AND WELL-BEING | 12 RESPONSIBLE CONSUMPTION AND PRODUCTION

PROJECT TITLE
A disinfectants database – substituting hazardous products in hospitals, schools and other public facilities

TARGET GROUP
Procurement, cleaning, and maintenance staff in public institutions

PREVENTION LEVELS
Primary and Secondary Prevention

Disinfectants used in public institutions play a critical role in ensuring hygiene and preventing infectious diseases. However, many disinfectants contain allergenic, toxic, or carcinogenic components, which can cause serious harm to both users' health and the environment. Before the entry into force of EU level regulations such as REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals) and the Biocidal Products Regulation, many of these risks remained invisible. This demonstrated that procurement processes focused solely on efficacy and price were inadequate and that health and environmental impacts also needed to be taken into account.

In this context, the Disinfectants Database (WIDES) initiative, launched in 1998 under the leadership of the Vienna Ombuds Office for Environmental Protection, developed an innovative model within sustainable public procurement that enables the selection of products with the lowest possible harm to the environment and human health. Although it began as a singular application, the project has over time created widespread impact at the national and international levels and has been cited by the European Commission as a good practice example.

The WIDES database classifies the components of disinfectant products on the market according to criteria such as efficacy, toxicity, allergenic potential, biodegradability, and environmental impact. The system details both the chemical contents of products and the possible health and environmental risks of those contents. Risk classes cover topics such as acute respiratory toxicity, irritation and corrosivity, allergenic potential, carcinogenicity/mutagenicity/reproductive toxicity, and acute and chronic behavior in surface waters. In this way, users can see not only the efficacy of a given product but also its impacts on human health and the environment.

The database is designed as a dynamic, not static, system. As new products are placed on the market, the system is regularly updated and information validated by independent experts is added to the database.

Procurement units in public institutions can make selections based not only on price and performance but also on environmental sustainability and health safety criteria. Use of this database has been made mandatory for all municipal institutions in Vienna.

The project is not limited to a technical system. Training programs have been organized for procurement staff and cleaning and maintenance workers, and publicly accessible training videos have been prepared. In this way, the "as much as necessary and by the correct method" use of disinfectants has been encouraged, improper applications have been prevented, and savings have been achieved in chemical consumption.

The effects of the initiative soon became visible. In hospitals, schools, and care homes in Vienna, the use of disinfectants containing hazardous components has significantly decreased.

For example, the consumption of surface and hand disinfectants containing carcinogenic, mutagenic, or reprotoxic (CMR) substances has been reduced from about one tonne to nearly zero. The amount of allergen containing disinfectants has dropped from 1.5 tonnes to nearly zero. The consumption of potentially carcinogenic substances used in floor cleaning machines has been halved, and triclosan containing microbial soaps have been completely replaced with safe alternatives.

These results have produced important gains not only for human health but also at the environmental level. Thanks to the reduction in chemical consumption, the amount of harmful substances entering the wastewater system has fallen, thereby reducing pressure on urban ecosystems.

At the policy level, in 2015 the Austrian Ministry of Labour issued a decision specifically recommending the use of WIDES to prevent pregnant workers from exposure to disinfectants containing carcinogenic or allergenic substances. This step ensured that the database was integrated into occupational health and safety policies not only locally but also nationally.

The development and updating of WIDES requires an annual cost of approximately €50,000. Funding is provided largely by the City of Vienna, the Austrian Workers' Compensation Board (AUVA), and federal ministries. Since this cost is even lower than the treatment costs of a single occupational disease case, the cost effectiveness of the application has been demonstrated.

The database is widely used not only in Austria but also internationally. WIDES receives approximately 1,500 visits per month and is considered a reference resource by users in different parts of the world. Being cited by the European Commission and the EU Green Public Procurement scheme shows that the system has become an important tool for policymakers at the European scale.

SOURCE: European Agency for Safety and Health at Work (EU-OSHA). (2019). Healthy Workplaces Good Practice Awards 2018-2019: Booklet update. https://osha.europa.eu/sites/default/files/HWC2018-19_GPA_Booklet_update.pdf

PROTECTING WORKERS FROM WELDING FUMES: A HIDDEN HEALTH RISK IN MANUFACTURING

LOCATION: United Kingdom
DATE: 2018 - ongoing

Welding Fumes | Occupational Health | Digital Tools

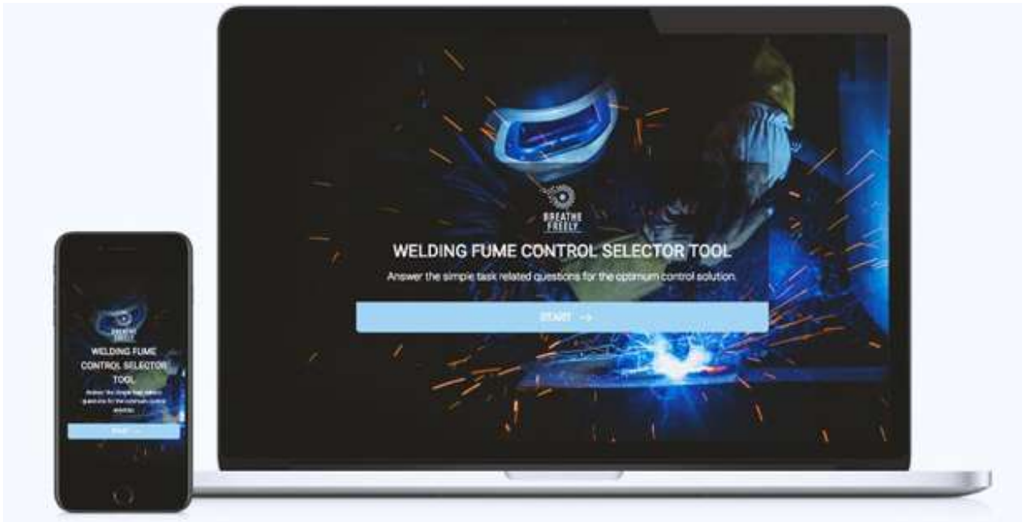
PEOPLE | PROSPERITY | PLACE | PARTICIPATION

3 GOOD HEALTH AND WELL-BEING | 8 DECENT WORK AND ECONOMIC GROWTH

PROJECT TITLE
Free web-based tool for selecting the best measures to protect workers from hazardous welding fumes

TARGET GROUP
Welding workers, manufacturing sector employees

PREVENTION LEVELS
Primary Prevention



Welding operations, while among the most common activities in the manufacturing sector, pose serious risks to workers' health. Exposure to welding fumes is among the primary causes of occupational diseases such as lung cancer, bronchitis, emphysema, and asthma. Every year, thousands of workers in the European Union face health problems arising from such exposures. Nevertheless, awareness among employers and employees remains low, and existing control measures are often insufficient or improperly implemented.

In response to this problem, an innovative initiative was developed in the United Kingdom within the "Breathe Freely in Manufacturing" campaign launched in 2017. Introduced under the title "Free web-based tool for selecting the best measures to protect workers from hazardous welding fumes," the tool is designed as an online selection system that facilitates the identification of the most suitable measures for controlling exposure to welding fumes.

The tool asks the user only four basic questions: type of welding, material used, duration of the task, and size of the part. Based on this information, the system generates a customized guidance page for the user. The guidance presents information on the effectiveness, cost, and applicability of recommended control methods and also rates the methods with stars from 1 to 5. In this way, both workers and employers can quickly see which measures are more reliable and effective and make informed decisions.

One innovative aspect of the tool is that, unlike standard information brochures, it provides personalized and situation specific recommendations. For example, in high risk stainless steel welding, local exhaust ventilation and extraction systems are recommended, while more cost effective solutions can be offered for shorter term or lower risk operations. This flexibility both protects worker health and helps employers avoid unnecessary costs.

Alongside listing technical measures, the tool has supported processes with managerial documents, guidance materials, and training resources related to occupational health. This has helped employers strengthen occupational health policies and ensure worker health at the organizational level.

The multi-actor structure played an important role in the success of the project. The work was developed under the leadership of the British Occupational Hygiene Society (BOHS), Toyota, BAE Systems, JCB, TWI, trade unions (TUC, Unite), and official authorities (the Health and Safety Executive - HSE) contributed directly to the process. This broad collaboration increased the tool's suitability for sectoral needs and its applicability.

The tool was launched in November 2018. In the first three months, it received 1,700 accesses, and approximately 200 guidance pages were downloaded. These data demonstrate the strong demand for such a solution in the manufacturing sector. The tool has increased awareness among workers about the dangers of welding fumes and enabled employers to select more appropriate and cost effective control measures.

Because the tool is free and can be translated into different languages, it offers a transferable model not only in the United Kingdom but internationally. Its potential use in sectors other than manufacturing where welding operations are conducted demonstrates the scalability of the model.

The web-based selection tool is a successful example of integrating digital technologies into occupational health. Thanks to personalized recommendations, cost effectiveness, free access, and multi-stakeholder collaboration, it contributes both to protecting employees and to enabling employers to make informed decisions. The tool has been recognized as a good practice example in Europe and has become a strong reference point in the digital transformation of occupational health policies. In the long term, this approach is expected to reduce the incidence of occupational lung diseases and indirectly support workforce productivity.

SOURCE: European Agency for Safety and Health at Work (EU-OSHA). (2017). Healthy Workplaces Good Practice Awards 2016-2017: Booklet. https://osha.europa.eu/sites/default/files/Healthy_Workplaces_Good_Practice_Awards_2016_2017_booklet.pdf

TRANSFORMING WORKPLACE CULTURE IN THE TECH SECTOR

LOCATION: Amsterdam, Netherlands

DATE: 2016 - ongoing

Occupational Health | Physical Activity | Workplace Health

PROJECT TITLE
Run Your Health - empowering employees of all ages to take action for their health

TARGET GROUP
Software and IT sector employees, all age groups

PREVENTION LEVELS
Primary Prevention

Run Your Health is an innovative workplace health program launched in Amsterdam, the Netherlands, in 2016 and continuing today. It aims to reduce the health risks caused by prolonged sedentary desk based work, which is common especially in the software and IT sectors. Today, a large proportion of technology employees spend more than eight hours a day at computers. This situation, combining physical inactivity with high stress, brings chronic health problems such as back and neck pain, musculoskeletal disorders, obesity, cardiovascular diseases, and psychosocial strain. At the same time, job satisfaction and productivity are adversely affected under these conditions. The project's purpose is to raise employees' health awareness, encourage them to take responsibility for their own well-being, and transform workplace culture to support health.

Within the scope of the program, information campaigns have been conducted, along with concrete arrangements that directly change the workplace environment. Height adjustable desks have been provided to employees, standing meeting tables have been placed in meeting rooms, and regular movement breaks have been organized throughout the day. Visual campaigns have been carried out to increase stair use, and small rewards have been designed for employees who choose stairs over elevators. In addition, areas equipped with simple fitness equipment have been created within the office to encourage employees to do short exercises during the day. These arrangements aim to instill small but sustainable behavioral changes in daily routines.

Individual support is one of the strong components of the program. Biofeedback devices have been provided to employees, enabling them to monitor their physical activity levels on a daily basis. Workshops focusing on nutrition, sleep hygiene, and stress management have been organized, addressing physical, mental, and social dimensions of health. In addition, psychosocial counseling and guidance services have been implemented to help employees achieve work life balance. In this way, the project has not been limited to simply increasing physical activity but has presented a holistic health approach.

One innovative aspect of the program is that it has been endowed with a motivational and enjoyable structure. In events called "health challenges," employees have been encouraged to increase their daily step counts, and performance results have been shared transparently. Supported by small rewards, these challenges emphasize solidarity and shared motivation rather than competition. Participants have been able to join the program at levels appropriate to their own physical capacity, enabling employees of all age groups to take an active role.

The results have become measurable in a short time. More than 250 employees who voluntarily participated represent half of the company's total workforce. The proportion of employees who exercise regularly has doubled, and average daily step counts have increased by 30%. There has been a 56% reduction in sedentary time, and survey results show that employees feel more energetic, motivated, and productive. In addition, a marked improvement in coping with stress and an increase in job satisfaction have been reported. These data show that the program positively affects individual health behaviors, organizational productivity, and employee engagement.

Funding has been provided largely by SAP, and the initiative has been integrated into the company's human resources and corporate social responsibility policies. Thus, the program has gone beyond a short term campaign to become a permanent component of corporate culture. In 2017, the second phase, "Run for Your Balance," was launched, in this phase, topics such as work life balance, happiness, and long term well-being were included in the program.

In conclusion, Run Your Health is an application with demonstrable measurable benefits for reducing physical inactivity and stress in the software sector. Thanks to participation rates, behavioral change indicators, and corporate integration, it has been recognized as a good practice example in Europe and has become a model that can be applied to sectors other than information technology. The project represents a holistic approach that addresses worker health not only through individual gains but also through the dimensions of organizational productivity and sustainability.

SOURCE: European Agency for Safety and Health at Work (EU-OSHA). (2017). Healthy Workplaces Good Practice Awards 2016-2017: Booklet. https://osha.europa.eu/sites/default/files/Healthy_Workplaces_Good_Practice_Awards_2016_2017_booklet.pdf

SPORT FOR ALL STUDENTS

LOCATION: Latvia

DATE: 2014 - ongoing

Child Health | Physical Activity | School Programme

PROJECT TITLE — Sporto visa klase

TARGET GROUP — Primary school students in grades 3-6 (children aged 9-12)

PREVENTION LEVELS — Primary Prevention

The Sport for All Students project, launched in Latvia in 2014, is a national programme developed to increase children's physical activity levels, prevent postural disorders, and strengthen motivation for sports. The increasingly widespread sedentary lifestyle among school age children has led to rises in obesity, musculoskeletal disorders, and general health problems. Implemented through cooperation among the Latvian Olympic Committee, municipalities, and educational institutions, the project is based on a multi dimensional approach that links sport not only with physical health, but also with social cohesion and academic achievement.

By enabling students to participate in three optional sports classes in addition to two compulsory physical education lessons per week, the programme has ensured regular daily physical activity throughout the week. Optional classes include general physical fitness, football, swimming, and various outdoor activities. In areas without swimming pools, children have been supported with different sports. Lessons last 40 minutes and are implemented in line with guidance materials prepared by the Latvian Academy of Sport Education. Municipalities have provided matching team outfits to boost children's motivation, and schools have increased the appeal of the programme by organizing handball tournaments, creative group work, and various sports activities throughout the year. At final events held at the end of the academic year, students are evaluated through both sports competitions and tests in subjects such as mathematics and language, and they collect points through projects that reinforce class solidarity. Beyond raising physical activity, the programme focuses on changing children's awareness and attitudes toward sport. By making sport a natural part of daily life, social skills such as discipline, time management, and team spirit have been strengthened among students. Parents and teachers have reported that children have become more energetic, focus better on lessons, and are more resistant to illness. Thus, the project has gone beyond individual health benefits to contribute to overall well being in the classroom environment.

Impact evaluations show that the programme has produced tangible outputs. In tests conducted each autumn and spring, parameters such as flexibility, balance, abdominal muscle endurance, and speed are measured, and anthropometric data are collected and analysed by experts from the Latvian Academy of Sport Education. Findings reveal significant increases in physical fitness among participating students. Positive developments have been observed not only in physical performance but also in social cohesion, discipline, and academic achievement.

The financing model is multi-stakeholder. For the 2015/2016 academic year, the total budget amounted to €106,000, 35% of which was provided by the state, the remainder was covered by municipalities and private sector supporters of the Latvian Olympic Committee. The amount of funding varies each year according to the number of participants, thus guaranteeing the programme's scalability. The legal basis is provided by Article 17 of the "Sports Policy Guidelines" adopted in 2013, which foresees funding support to ensure sufficient physical activity and awareness of sport in society.

SOURCES: European Commission. School health programs.
https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/256
Olimpiade.lv. Nosl̄egusies sporto visa klase desmitā sezona.
https://www.olimpiade.lv/en/zinas/svk-zina/noslegusies-sporto-visa-klase-desmita-sezona

SCALING UP SIMPLE HEALTH INTERVENTIONS FOR CHILDREN IN SOUTHEAST ASIA

LOCATION: Cambodia, Indonesia, Lao PDR, Philippines
DATE: 2011 - 2021 (pilot 2008-2011)

School Hygiene | Child Health | Integrated Education Policies

PROJECT TITLE — Fit for School
TARGET GROUP — Primary school students, school communities, ministries of education
PREVENTION LEVELS — Primary Prevention

Implemented in Southeast Asia to improve child health and strengthen school environments in terms of hygiene and health, the Fit for School programme is a regional model that integrates simple yet effective interventions with education policies. Its starting point was the "Essential Health Care Program," launched in the Philippines in 2008. This pilot was based on three core routines: daily group handwashing with soap, daily group tooth brushing with fluoride toothpaste, and twice yearly mass drug administration against intestinal parasites. These low cost practices yielded striking results in terms of preventing communicable diseases, reducing dental caries, and developing lasting health habits in children. Building on the success of the pilot, and with support from GIZ (German Development Cooperation) and SEAMEO-INNOTECH, the programme was scaled regionally in 2011 and integrated into the official policies of ministries of education in countries such as Cambodia, Indonesia, and Lao PDR.

The programme centres on interventions designed to achieve high impact at low cost. Simple handwashing stations were installed in schools, and access to soap and clean water was secured. Teachers guided students and incorporated these routines into the daily class schedule. Group tooth brushing activities were integrated with classroom learning, and mass drug administration was carried out in coordination with ministries of health.

A key feature of this approach is that standard procedures can be adapted to each country's education curriculum and cultural conditions. Thus, the programme has ceased to be merely a health initiative and has become a natural part of national education systems.

One innovative aspect of the programme is that, beyond its focus on hygiene and health, it functions as a policy instrument that strengthens the capacity of education systems. Minimum hygiene standards in schools were established through ministries of education, and an instrument called "FIT-PAS" was developed for monitoring and evaluation. In addition, by aligning with the United Nations' "Three Star Approach" in the WASH in Schools field, the programme has been integrated with international norms. Teachers and school administrators have served as active carriers of implementation, while parents and local communities have also been involved. In this way, a culture of ownership has been created not only in schools but across communities.

The results are compelling. Schools implementing the programme have recorded marked reductions in dental caries, the institutionalization of daily handwashing with soap, and declines in parasitic infections. Long-term evaluations in the Philippines have shown that daily group tooth brushing with fluoride toothpaste provides a 24% protective effect among children. In low-resource countries such as Cambodia and Lao PDR, the programme has improved health indicators, reduced school absenteeism, and strengthened students' focus and learning processes. Teachers have reported increased health awareness among students along with the transfer of positive behaviours to the home environment.

The financing structure is one of the strongest aspects of the programme's sustainability. GIZ and SEAMEO-INNOTECH provided technical support and financing, while local governments integrated the programme into national budgets to ensure long term feasibility. Thanks to this multi-actor model, Fit for School has moved beyond a short term project to become an integral part of education policies. In addition, experience has been shared among countries via regional knowledge exchange platforms, and capacity building efforts have been supported.

In conclusion, Fit for School stands out as a powerful initiative that has transformed child health and education policies in Southeast Asia. Through simple, low cost, and adaptable interventions, it has instilled healthy habits in children's daily lives, contributed to reducing health inequalities, and raised hygiene standards in schools.

With the ownership of ministries of education and the support of regional institutions, the programme has generated improvements not only in health indicators but also in the quality and sustainability of education.

SOURCES: United Nations. Regional Fit School Programme supports ministries of education in Cambodia, Indonesia and Lao PDR.
https://sdgs.un.org/partnerships/regional-fit-school-programme-supports-ministries-education-cambodia-indonesia-lao-pdr
Fit for School International.
https://fitforschool.international/

BUILDING HEALTHIER COMMUNITIES FOR CHILDREN AND YOUTH

LOCATION: Netherlands

DATE: 2010 - ongoing

Childhood Obesity | Healthy Lifestyle | Social Marketing

PROJECT TITLE — JOGG - Jongeren op Gezond Gewicht

TARGET GROUP — Children and youth aged 0-19, parents, school communities

PREVENTION LEVELS — Primary Prevention

Launched in the Netherlands in 2010, JOGG: Healthy Weight in Youth is designed as a community based health initiative to address the growing problem of overweight and obesity among children and adolescents. The programme aims to change children's nutrition and physical activity habits and establish a robust cooperation network among local governments, schools, parents, sports clubs, health professionals, and the private sector. This holistic approach seeks to support a healthy lifestyle not only in the school environment, but across all areas of children's lives, including neighbourhoods, homes, and community spaces.

Core goals of the programme include increasing daily physical activity levels, reducing sugary drink consumption while promoting water intake, strengthening regular and healthy breakfast habits, increasing fruit and vegetable consumption, and ensuring the availability of healthy options in every setting where children are present. Accordingly, JOGG is carried out within a broad social responsibility framework that includes not only children, but also parents, supermarkets, sports clubs, the business community, and public institutions.

Implementation operates simultaneously at national and local levels. The national JOGG Foundation provides methodological support, communication materials, and scientific research findings to municipalities, while at the local level each municipality appoints its own JOGG coordinator to plan activities tailored to local needs. These activities include increasing healthy food options in school canteens, limiting sugary drinks at sports venues, running campaigns to instil water drinking habits among children, and expanding playgrounds. Municipalities join the programme with a minimum three year commitment, which ensures long term sustainability.

One innovative aspect of JOGG is the use of social marketing strategies as a primary tool for behaviour change. Campaigns encouraging children to play outdoors or motivating parents to find healthy packed lunches appealing are designed to align with the motivations of target groups. This ensures that the programme is not limited to restrictive or prohibitive measures but instead has an appealing and participatory structure. In addition, public-private partnerships have become key elements of financial and operational sustainability.

Supermarket chains, food producers, and health insurance companies are among the programme's active stakeholders, helping support healthy lifestyles across different sectors of the economy and society.

Results have created notable effects in many cities. In Zwolle, the proportion of overweight primary school children fell from 12.1% to 10.6% between 2009 and 2012. In Utrecht, the rate of overweight children in JOGG areas fell from 25% to 22% between 2010 and 2014. In Dordrecht, the rate decreased from 35.2% to 34.1% between 2012 and 2013, while in two JOGG schools in Amsterdam it fell from 41.5% to 37.4% between 2011 and 2013. In Rotterdam, the rate stabilized by 2013. These findings show that the JOGG approach generates positive public health outcomes at the community scale.

Financing consists of public resources and private sector contributions. Support from the Ministry of Health, Welfare and Sport, annual contributions from municipalities (€5,000-€10,000), and financial support from private partners ensure the programme's sustainability.

At the local level, each municipality employs at least a part time JOGG coordinator and guarantees the continuity of implementation. Monitoring and evaluation are integral to the programme: municipalities measure impacts through annual reports, and children's body mass index, eating habits, and physical activity levels are tracked regularly.

JOGG's comprehensive structure sets out a multi-layered strategy that addresses health not only at the level of individual behaviour change but also through social, environmental, and institutional dimensions. In social settings such as schools, sports clubs, workplaces, and neighbourhoods, infrastructure supporting healthy living has been established, guiding children toward healthy choices in every environment.

SOURCES: European Commission. Nutrition and health programs. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/55
JOGG. https://jogg.nl/

SCHOOL-BASED HEALTH EDUCATION INITIATIVE

LOCATION: Germany
DATE: 1991 - ongoing

Child Health | Health Education | Life Skills

PEOPLE | PARTICIPATION | PLACE | 3 GOOD HEALTH AND WELL-BEING | 4 QUALITY EDUCATION

PROJECT TITLE
TARGET GROUP
PREVENTION LEVELS

KLASSE2000
Primary school students aged 6-10, students in special education schools, families, and teachers
Primary Prevention

Launched in the 1991-1992 school year in Germany, the KLASSE2000 Programme is today one of the most comprehensive school based health education initiatives implemented nationwide. Developed for primary school students aged 6-10, it is designed to teach children healthy lifestyles, enable them to take responsibility for their own health, and equip them with essential life skills. The programme's main focal points are healthy eating, regular exercise, relaxation techniques, recognizing and managing emotions, peaceful conflict resolution, and developing resistance to harmful habits such as tobacco and alcohol.

The programme's structure is based on specially trained health promoters who work alongside classroom teachers. Each school year, around 14 interactive lessons are held, providing children with learning experiences through games, visuals, and practical activities. Detailed guides have been prepared for teachers and informative materials for parents, ensuring that the intervention is not confined to the school environment but is also carried into family life. This continuity has made it easier for children to develop consistent behaviours at home and at school.

KLASSE2000 focuses not only on short term gains but also on long term behaviour change. Randomized, controlled longitudinal research conducted by Bielefeld University has revealed that the programme produces lasting effects on children's nutrition and physical activity behaviours.

The IFT Nord study, carried out between 2005 and 2008 with follow-ups in 2009 and 2011, showed significantly lower rates of smoking and alcohol use among children participating in the programme compared with control groups. Evaluations conducted particularly at the 7th grade level have demonstrated that education delivered at an early age plays a critical role in preventing risky behaviours during adolescence.

The programme's impact has not been limited to health behaviours, it has also produced marked results in children's social and emotional development. Participating students have made progress in cooperating, expressing their emotions in healthy ways, and resolving conflicts without resorting to violence. This shows that the programme has a transformative effect on classroom climate and school life as well as on individual health gains.

The financing model relies largely on civil society support. The programme's budget is covered by donations and sponsorships, with regular support provided by Lions Clubs, health insurers, parent associations, companies, and individual sponsors. In the 2014-2015 school year, the total budget amounted to €3.8 million, only 12% of which was covered by public funds. This demonstrates the strong backing the programme receives from civil society and the private sector. The legal basis is provided by recommendations from the Standing Conference of the Ministers of Education and Cultural Affairs (KMK), state education plans, and the national Prevention Act.

The programme has been monitored and evaluated systematically for many years. Supported by scientific evidence, these impacts have made KLASSE2000 an exemplary practice not only in Germany but also across Europe. By instilling healthy lifestyle habits at an early age, contributing to the prevention of risky behaviours, and strengthening social skills, it stands out as a comprehensive school based health education model.

SOURCES: European Commission. Prevention and education in schools.
https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/238
Klasse2000.
https://www.klasse2000.de/

COMMUNITY PARENT EDUCATION PROGRAMME

LOCATION: Sweden

DATE: 2000 - ongoing

Parent Training | Child Behaviours | Community-Based Intervention

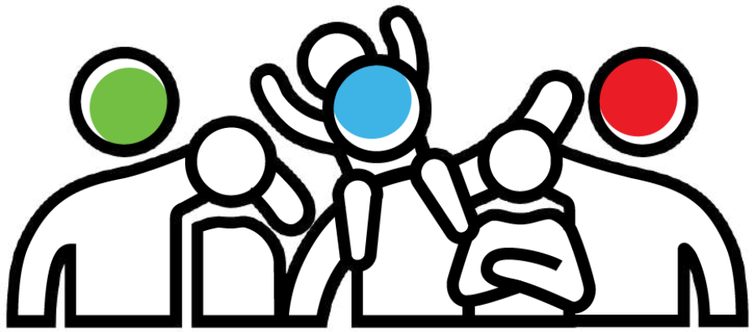
PEOPLE | PARTICIPATION

3 GOOD HEALTH AND WELL-BEING | 4 QUALITY EDUCATION | 16 PEACE, JUSTICE AND STRONG INSTITUTIONS

PROJECT TITLE
Community Parent Education Programme (COPE)

TARGET GROUP
Parents of children (especially ages 4-12) who show symptoms of behavioural disorders

PREVENTION LEVELS
Secondary Prevention



Developed in Sweden in the early 2000s, the Community Parent Education Programme (COPE) is an innovative parenting-education model designed to reduce behaviour problems in children and strengthen parents' child-rearing capacities. Its starting point is that symptoms commonly observed in childhood, such as oppositional defiant disorder (ODD) and attention-deficit/hyperactivity disorder (ADHD), adversely affect academic achievement, social cohesion, and family relationships. Research shows that if such behavioural problems are not addressed at an early stage, they lead to more serious mental health and social-integration problems in later years. In this context, COPE aims to create long term protective effects in children's development by involving parents in early-intervention processes.

COPE's implementation model consists of weekly sessions lasting approximately two hours each over a total of ten weeks. Participants usually come together in large groups of 25-30 parents. Programme leaders use short video clips, dramatizations, and role-play activities to open discussion on everyday parenting challenges. During this process, parents learn behaviour-management strategies such as reinforcing children's positive behaviours, ignoring minor misbehaviours, planning ahead to prevent crises, and developing effective reward systems.

In addition, the PASTE approach to problem-solving (Pick a problem, Assess alternatives, Select an option, Try it out, Evaluate the effect) provides parents with a practical, applicable method.

One of the programme's most innovative aspects is its large-group format. Compared with small-group or individual counselling, COPE can reach more parents at the same time and offers a cost effective solution. Group dynamics allow parents to learn from each other's experiences, build supportive social networks, and realize they are not alone. This collective-learning model increases parents' motivation and the likelihood that they will apply the strategies they learn in daily life.

Evaluation studies conducted in Sweden have shown that COPE is particularly effective in reducing behaviour problems. Research by Thorell and colleagues (2009) shows marked decreases in aggression, defiance, and hyperactivity among children whose parents participated in the programme. Parents also reported developing a stronger sense of control over their parenting skills and experiencing lower stress levels. While these improvements were more pronounced in non-clinical groups, effects were more limited among children with more severe symptoms. This underscores how critical the programme is for early intervention.

One of COPE's strengths is its ease of implementation and adaptability to different contexts. The programme's methodology has been designed with the flexibility to be adapted to different cultural and social conditions. The Swedish experience shows that a sustainable model can be created through cooperation with different institutions such as municipalities, school health services, and community centres. The programme has not only improved the parent-child relationship but also positively affected children's behaviour in school settings and their relationships with teachers.

In terms of financing, COPE stands out as a low cost intervention. Thanks to the group format, a single leader can work with dozens of parents at the same time, significantly reducing the cost per training session. During implementation, voluntary organizations and local health authorities have also played supportive roles, ensuring that the programme does not remain a short term project, that it is adopted at the societal level, and that it can be scaled across different regions.

The programme is an effective, cost effective, and scalable model aimed at improving parenting skills and reducing behaviour problems in children. The Swedish experience shows that empowering parents plays a critical role in child development. With its effectiveness supported by scientific evidence, its group-based structure, and its community-centred approach, COPE is considered a strong good practice example that can be expanded across Europe.

SOURCES: EUDA. Community Parent Education Programme (COPE): A large group community-based programme for parents and children with behavioural disorder symptoms.
https://www.euda.europa.eu/best-practice/xchange/community-parent-education-programme-cope-large-group-community-based-programme-parents-children-behavioural-disorder-symptoms_en#impexp
Young, B., & Forehand, R. (2007). The Community Parent Education Program (COPE): Treatment effects in a clinical and a community-based sample. Journal of Child and Family Studies, 16(3), 393–407.
https://www.researchgate.net/publication/26281953_The_Community_Parent_Education_Program_COPE_Treatment_Effects_in_a_Clinical_and_a_Community-based_Sample

STRENGTHENING CARE INFRASTRUCTURE AND GENDER EQUALITY

LOCATION: Latin America & the Caribbean, Bogotá, Colombia

DATE: 2020 - ongoing

Care Infrastructure | Women's Empowerment | Gender Equality

PROJECT TITLE — Agence Française de Développement (AFD)

TARGET GROUP — Women domestic workers, women and children, disadvantaged communities

PREVENTION LEVELS — Secondary Prevention

The Agence Française de Développement (AFD) has implemented two significant initiatives in Latin America and the Caribbean to strengthen care infrastructure and advance gender equality. The first initiative, covering the 2020-2025 period, is a project aimed at improving the conditions of women employed in paid domestic work. Making domestic work visible and professionalized, advocating for fair labour rights, and promoting social enterprises that increase women's economic autonomy have formed the project's core components. Focusing especially on women from Afro-descendant and Indigenous communities, the programme has adopted an inclusive approach that addresses gender equality alongside race, ethnicity, and socioeconomic vulnerability.

To this end, AFD developed a co-financing model in partnership with Fondation Chanel, with each party covered 50% of the budget and providing a total resource envelope of approximately €1 million. In addition, partnerships were established with the private sector and local cooperatives, and training was provided to women in financial management, organizing, and marketing.

The programme's performance indicators included organizing dialogue sessions on the rights of domestic workers, developing regional advocacy agendas, strengthening the legal framework on domestic work in Brazil, and providing training to women workers to address violations of trade-union rights and gender-based violence. Thus, the project created advocacy capacity at the institutional level alongside individual empowerment.

The second initiative was carried out in Bogotá, the capital of Colombia, within the framework of the 2020-2024 Municipal Development Plan. In this scope, AFD provided a budget-support loan of up to €150 million to support projects focusing on gender equality, care infrastructure, and sustainable development. The main beneficiaries of the programme have been women, children, and disadvantaged groups. Its most notable implementation component has been the centres known as "Manzanas del Cuidado" ["Care Blocks"]. These centres offer services such as free laundries to ease women's care burden, and they have provided basic infrastructure at a societal scale where such services are absent in homes.

In this way, women's care responsibilities have been reduced, and opportunities for education, employment, and participation in social life have increased.

The financing model has been based on loan support, multi-year policy dialogue, and technical cooperation. During the COVID-19 pandemic, aligning short term emergency measures with long term development goals posed a significant challenge. For this reason, regular meetings were held among stakeholders, and coordination was strengthened between the Bogotá City Government, the Secretariat for Women, the Urban Development Institute (IDU), and civil-society organizations. These partnerships have ensured an inclusive and holistic impact in strengthening care infrastructure.

In conclusion, these two AFD initiatives have made significant contributions both to strengthening the economic and social rights of women domestic workers in Latin America and to the development of gender-equality-based care services in Bogotá. Through innovative financing models, private sector partnerships, and collaborations with local governments, AFD has demonstrated that care infrastructure supports not only social welfare but also economic development. These projects consolidate AFD's leading role in investment strategies that promote gender equality among public development banks and provide a model that can be cited internationally.

SOURCE: UN Women. (2025, February). Financing care infrastructure. https://www.unwomen.org/sites/default/files/2025-02/financing-care-infrastructure-en.pdf

PROMOTING EQUITY AND COMMUNITY PARTICIPATION IN URBAN HEALTH

LOCATION: Pasig City, Philippines
DATE: 2023 - ongoing

Urban Governance | Health Equity | Community Participation

PROJECT TITLE
TARGET GROUP
PREVENTION LEVELS

WHO Initiative on Urban Governance for Health and Well-being
Urban population, local governments, health institutions, community stakeholders
Secondary prevention

Launched in Pasig City, one of the Philippines' rapidly urbanizing areas, the Urban Governance for Health and Well-being Initiative is an innovative model developed in collaboration with the WHO. The dense population, infrastructure pressures, environmental pollution, and social inequalities brought by urbanization show that health services in urban areas cannot remain limited to medical interventions alone. In this context, the initiative aims to place the social, economic, and environmental determinants that directly affect health at the center of local governance processes. The program is built on three core objectives: to create policy frameworks that promote equity in health; to increase institutional capacity at local and national levels; and to systematically include community participation in decision-making processes.

During implementation, a comprehensive research and evaluation infrastructure was established in Pasig City. Data is being collected across the city to support governance models focused on health and well-being, existing policies are being reviewed, and community priorities are being identified.

In this process, municipal officials, universities, civil-society organizations, and community representatives play active roles. In addition, an online training platform called "Urbanlead" ("City Pioneer") was developed for city leaders, offering modules to decision-makers on health-oriented planning, post-COVID-19 resilience, and inclusive governance. In this way, alongside technical solutions, the program has also provided a strengthening framework for leadership capacity and governance skills.

Through participatory processes in the program, community members have become not only passive recipients of services but also active decision-makers in policy formation. This has enabled health policies to respond better to community needs and has opened the way for social innovation. Outputs obtained during implementation include city-based data-reporting mechanisms, the joint identification of health priorities with local leaders, the documentation of good practices, and capacity-building activities among stakeholders.

The innovative dimension of the governance initiative lies in addressing health inequalities not merely as a problem of access to health services, but as an issue related to broader urban determinants such as housing, education, environment, transport, and safety. It treats health not within a narrow medical frame but as an integral component of urban well-being. For example, air quality, housing conditions, and the accessibility of public spaces are assessed within the program's health indicators. In this way, direct integration between urban planning and health policies is achieved. Moreover, multi-stakeholder collaboration among the WHO, the Philippine Department of Health, academic institutions, and civil-society organizations contributes to making this integration lasting and sustainable.

The program's short-term results are promising. Health priorities jointly identified by community representatives and local leaders in Pasig City have been reflected in the municipality's planning documents, and regular reporting mechanisms have been established for the collection and analysis of city-based health data.

Thanks to the public's active participation in the process, the social acceptance of decisions has increased and health policies have become more inclusive. In addition, the governance capacity of local government units has been strengthened, which has helped them adapt more rapidly to the new health and social challenges that emerged in the post-COVID-19 period.

SOURCES: World Health Organization. Urban governance for health and well-being: Pasig City, Philippines.
https://www.who.int/initiatives/urban-governance-for-health-and-well-being/pasig-city--philippines
United Nations Global Marketplace. Public notice: 192565.
https://www.ungm.org/Public/Notice/192565

ENVIRONMENTALLY SUSTAINABLE AND RESILIENT GREEN REFUGEE CAMP

LOCATION: Minawao, Cameroon

DATE: 2017 - ongoing

Refugee Camps | Environmental Sustainability | Climate Resilience

PROJECT TITLE

TARGET GROUP

PREVENTION LEVELS

Creating an Environmentally Sustainable and Resilient Green Refugee Camp

Refugees migrating from Nigeria (especially women and children), local communities

Primary prevention

Located in northern Cameroon, the Minawao Refugee Camp has become a shelter for tens of thousands of people who fled Boko Haram attacks in Nigeria. Established in 2013 with a capacity of 15,000 people, the camp quickly exceeded its limits and, as of 2021, began hosting 69,622 people. Of this population, 61% are children and 54% are women and girls. The camp's rapid growth increased pressure on basic resources such as water and energy; intensive firewood use accelerated deforestation; combined with desertification and climate change, this deepened ecological degradation. This process not only made living conditions more difficult for refugees but also triggered tensions with surrounding local communities based on competition over resources.

To alleviate these problems, in 2017 the UN High Commissioner for Refugees (UNHCR), the Lutheran World Federation (LWF), and the Netherlands-based Land Life Company launched a comprehensive ecological transformation initiative with $2.7 million in support from the Dutch National Postcode Lottery.

The project's main objective was to turn Minawao into a camp that is environmentally sustainable, resilient, and offers dignified living conditions. Implementation rested on four main pillars: construction of environmentally friendly shelters; afforestation and land restoration; transition to sustainable energy; and capacity building for refugees.

To improve housing conditions, the project moved away from plastic and temporary wooden structures and used locally produced unfired bricks. More than 14,850 family shelters were built, improving the living conditions of 22,445 people. These structures offered more sustainable solutions in terms of both durability and environmental compatibility. In the energy field, 11,460 energy-efficient stoves were distributed, and two production centers were established for bio-briquettes derived from agricultural residues. Thus, women and young people received training in briquette and stove production, creating income opportunities while reducing pressure on forests.

Afforestation and ecological restoration constitute one of the project's strongest components. Thanks to the Cocoon technology developed by the Land Life Company, more than 300,000 trees were planted and seedling survival rates increased from 10% to 85%. Using this method, 119 hectares were reforested, 26 new nurseries were established, and a sustainable ecosystem was built from which communities can obtain fuelwood, construction materials, and food products in the long term. Over the next 20 years, production of 2,160 tons of cashew, 8,400 tons of neem oil, and 160,000 tons of animal feed is projected. Nature clubs were also established for children, fostering environmental awareness among young people.

One of the innovative aspects within the is the joint consideration of environmental protection and livelihoods. Afforestation and energy-efficiency activities have not only reduced carbon emissions and erosion, but also created new opportunities for agriculture and animal husbandry. Women's participation in production supported their economic independence and strengthened their social roles. In this way, the project has made a notable contribution to gender equality and economic inclusion as well.

The project's tangible outputs are highly impressive. With the construction of 14,850 shelters, access to safe housing has increased; the 11,460 energy-efficient stoves have reduced firewood consumption and harmful emissions. Planting more than 300,000 trees has strengthened carbon sinks and revitalized ecosystem services. The income that women and young people obtained from briquette production has supported household economies. Educational activities have helped instill environmentally responsible behaviors among both children and adults.

SOURCES: Urban Agenda Platform. Creating environmentally sustainable and resilient green refugee camp.
https://www.urbanagendaplatform.org/best-practice/creating-environmentally-sustainable-and-resilient-green-refugee-camp
Lutheran World Federation. Cameroon: Protect environment, create employment.
https://lutheranworld.org/news/cameroon-protect-environment-create-employment

ADVANCING CARBON REDUCTION AND SUSTAINABLE DEVELOPMENT

LOCATION: Bristol, United Kingdom
DATE: 2011 - ongoing

Smart City | Carbon Reduction | Renewable Energy

PROJECT TITLE
TARGET GROUP
PREVENTION LEVELS

Smart City Bristol
Urban residents, local businesses, educational institutions, energy and transport sectors
Primary Prevention

Bristol, with the Smart City Bristol programme it launched in 2011, stood out as one of the United Kingdom's most innovative cities. The programme's starting point was the city's setting, using 2005 as the baseline, of a 40% CO_2-reduction target by 2020, thereby doubling the European Union's 20% reduction standard. This ambitious goal made Bristol a pioneering city in carbon reduction, community participation, technology development, and sustainable development. The programme conceived climate action not merely as a technical transformation but as a social transformation that permeates residents' daily lives.

The programme was shaped around three main themes: Smart Energy, Smart Mobility, and Smart Data. Under these headings, numerous pilot and permanent projects were developed, such as smart meters, smart-grid applications, electric-vehicle projects, the Traffic Control Centre, the Freight Consolidation Centre, and open-data platforms. One of the most notable applications, the Knowle West Living Lab model, involved local people directly in the technology-development process. Feedback from citizens helped turn pilot applications into more accessible solutions with higher public acceptance.

This approach laid the foundation for a human-centred, rather than technology-centred, smart-city vision.

In 2015, Bristol's receipt of the European Green Capital title became a turning point for the programme. With this title, the city assumed an international climate-leadership role and implemented innovative initiatives such as the Bristol Prize, an international clean-technology festival, school-based climate-education programmes, and the "Grass Roots Catalyst Fund". In the same period, an additional £7 million was secured to finance more than 50 sustainability projects. These included solar-energy investments, community-based renewable-energy initiatives, and programmes to combat energy poverty. The programme's effects were observed in a short time. With the "3e Houses" and "STEEP" projects, energy consumption in pilot residential areas decreased by up to 20%, and online analyses and GIS-based energy maps were developed using data obtained from smart meters. The marked reduction of energy use in schools and public buildings contributed to children and young people gaining climate awareness. Through the "So La Bristol" project, solar power and battery-storage systems were integrated into daily life at the neighbourhood scale.

In this way, low-carbon lifestyles spread across different segments of society.

In the field of mobility, electric vehicles and low-emission public-transport projects were supported, and traffic congestion and air pollution in the city centre began to decline. Open-data platforms enabled residents to access energy, mobility, and environmental data directly. Thus, the transparency of urban policies and citizen participation were strengthened.

The financing model played a critical role in the programme's success. The municipality led co-ordination from its own budget, yet many projects were supported by the European Commission, Horizon 2020, Ofgem, and the UK Government. This structure ensured the sustainability of projects without straining Bristol's limited local resources. In addition, the strong support of the directly elected mayor and the decisions taken by the city council within the framework of climate security reinforced the programme's political legitimacy.

Bristol also joined the Rockefeller Foundation's 100 Resilient Cities Network and, by appointing a Chief Resilience Officer, developed a holistic vision on carbon reduction, disaster preparedness, the elimination of social inequalities, and economic resilience. In this way, climate action and social inclusion were addressed within the same policy framework.

The results have been impressive at both environmental and social levels. While the city's carbon emissions declined rapidly, public awareness of climate and energy increased, and local businesses and universities contributed actively to the smart-city vision. The additional employment created for the local economy and clean-technology investments made the city one of Europe's green-innovation centres.

SOURCE: Metropolis. Smart City Bristol.
https://use.metropolis.org/case-studies/smart-city-bristol

PROMOTING GLOBAL SUSTAINABILITY AND TREE PLANTING

LOCATION: Florence, Italy (Implemented in 16 countries)

DATE: 2010 - ongoing

Agroforestry | Carbon Reduction | Sustainable Development

PROJECT TITLE
TARGET GROUP
PREVENTION LEVELS

Treedom: Let's Green the Planet
Small-scale farmers, rural communities, companies, individual users
Primary Prevention

Launched in 2010 in Florence, Italy, the Treedom: Let's Green the Planet initiative quickly became one of the most innovative environmental projects on a global scale. The defining feature of Treedom is that it enables individuals and institutions to support tree planting in different parts of the world via an online platform. However, rather than being merely a sapling-planting campaign, the initiative is a holistic sustainability model that promotes agroforestry methods, provides direct financial and technical support to small farmers, strengthens biodiversity, and aims to reduce carbon emissions.

The project operates by sending the saplings that users purchase through the platform to small farmer cooperatives in developing countries. Farmers not only plant the saplings; they also receive training in maintenance, organic farming, composting, soil improvement, and agroecological methods. In this way, the project contributes to combating climate change while at the same time increasing food security in rural communities, diversifying livelihoods, and strengthening economic resilience. Social inclusion has been supported by encouraging the active participation of women and young people in the process.

One of Treedom's innovative aspects is its approach to digital transparency. Each planted tree is recorded with geographic coordinates, photographed, and can be tracked through an online profile page assigned to the user. Users can follow the tree's growth, measure carbon offset, and gift the tree to someone else. This model turns environmental action into a personal experience, enabling individuals to build a stronger bond with nature. Thus, environmental responsibility ceases to be an abstract notion and becomes a concrete form of participation integrated into daily life.

As of 2020, Treedom's global impact had reached striking proportions. In 16 countries (Nepal, Kenya, Haiti, Cameroon, Senegal, Malawi, Tanzania, Colombia, Guatemala, Ghana, Ecuador, etc.), more than 1 million trees were planted, and 67,000 small farmers were directly included in the programme. Through these practices, an estimated 340,000 tons of CO_2 were absorbed, and problems such as drought, deforestation, and soil erosion were alleviated in many regions. Agroforestry methods increased carbon sinks and improved soil fertility, water-retention capacity, and biodiversity.

Significant outcomes have also been achieved on the social dimension. With fruit trees and income-generating species, farmers both increased dietary diversity and entered new markets to gain economic benefits. Women's participation in the production of value-added products such as briquettes, jam, fruit juice, and spices strengthened women's leadership and economic independence. In this way, Treedom has become an effective tool for environmental protection, rural development, and social equality.

At the corporate level, Treedom has served as a platform that facilitates the private sector's participation in climate action. More than 2,300 companies have created their own "corporate forests" through Treedom, thereby carrying out carbon offsetting and obtaining strong indicators for their sustainability reports. For companies, the transparent recording of each tree has made environmental responsibility visible and increased brand value. In this respect, Treedom offers a scalable financing model for individual and corporate climate action.

Treedom's vision is not only to bring millions of trees together with the soil, but also to ensure that environmentally sensitive behaviours become a cultural norm. In this context, the initiative proves that small individual actions, for example, a person planting a single tree, can evolve into a large-scale climate movement. This approach integrates climate action around a shared purpose for individuals, communities, and companies.

SOURCES: Urban Agenda Platform. Let's green: Planet Treedom.
https://www.urbanagendaplatform.org/best-practice/lets-green-planet-treedom
Treedom.
https://www.treedom.net/en

REVERSE VENDING MACHINES ADDRESSING SOLID WASTE CRISIS

LOCATION: Lebanon

DATE: 2015 - ongoing

Reverse Vending Machines | Waste Circularity | Behavioral Incentives

PROJECT TITLE

TARGET GROUP

PREVENTION LEVELS

Reverse Vending Machines (RVM)
Public users, low-income groups, municipal authorities, and environmental institutions
Primary prevention

In 2015, the municipal solid-waste crisis in Lebanon created a deep rupture in the country's environmental and social agenda. In a country that produces approximately 6,500 tons of municipal waste per day, only 15% of the waste is recycled, while the rest is sent to sanitary landfills or dumped at uncontrolled sites. This situation threatened environmental health, especially in large cities, polluted groundwater and surface waters, and the "mountains of trash" increased both health risks and social unrest. In this climate of deadlock, UN-Habitat and the Lebanese Ministry of Environment launched an innovative pilot project titled Reverse Vending Machines. The primary aim of this initiative is to encourage source separation of waste and to involve the public directly in the process. The project envisages returning recyclable waste (plastic, metal, and glass bottles) to the system directly through machines. When users deliver their waste through these machines, credit is loaded onto their mobile phone lines in return. This method has turned environmental protection not only into a technical service but also into a socially beneficial mechanism supported by economic incentives.

In the pilot phase, 11 reverse-vending machines were placed in various regions of Lebanon.

Locations were chosen by considering proximity to recycling facilities and ease of public access. After accepting bottles, the machines load phone credit to provide an instant reward to the user. Agreements signed between the Ministry of Environment and the telecommunications companies Alfa and Touch secured the sustainability of this system. In addition, to increase public awareness, online competitions were planned to reward the most-used machine, and access was facilitated by moving underused machines to different regions.

From a financial perspective, installing each RVM cost approximately US$12,000. This cost covers the purchase and installation of the device. While municipalities were made responsible for operating and maintaining the machines, UN-Habitat and the Ministry of Environment undertook monitoring and tracking systems. Municipalities have met maintenance costs through revenue-sharing agreements concluded with recycling companies. For example, revenues amount to US$100–170 per ton for plastic, US$50–60 for glass, and about US$600 for metal. This model has reduced the financial burden that waste management imposes on municipalities while at the same time creating new sources of revenue.

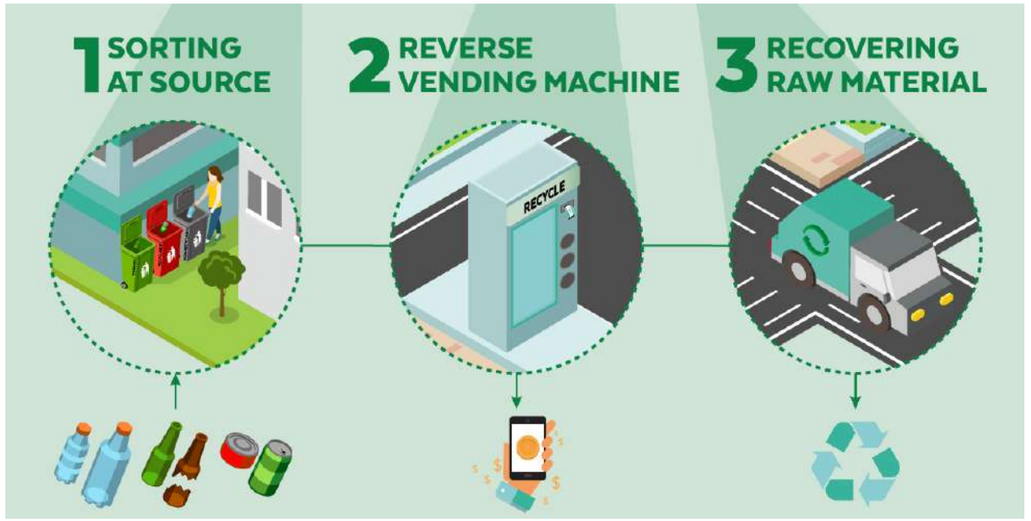
One of the project's strengths is that it puts community participation at the centre. For low-income individuals in particular, the practice of delivering waste in exchange for phone credit has become an economically attractive incentive. This approach has both increased environmental awareness and strengthened the participation of disadvantaged groups in the project. In addition, capacity-building training on maintenance and operation were provided to municipal staff and municipal police, thereby ensuring local ownership.

Results were observed in a short time. The project accelerated the return of recyclable waste to the economy, reduced the amount sent to dumps, and improved quality of life in cities. The visibility of the circular-economy approach in society has been further strengthened through the active participation of different social groups such as youth and women. Moreover, the spread of a source-separation culture at the community level has been an important step toward long-term behaviour change.

The innovative aspect of the project lies in integrating waste management with a behavioural-incentive mechanism. Whereas recycling in traditional systems is largely dependent on voluntary participation, here individuals were offered a direct and measurable economic benefit. This approach has transformed waste management from an abstract environmental problem into a concrete and attractive practice in daily life.

In the long term, the plan is to scale up this model in more municipalities.

Beyond Lebanon, it also carries the potential to be adapted as a solution for Mediterranean cities experiencing similar waste crises. The RVM system is being evaluated as a policy instrument that supports environmental protection, social development, and economic inclusion.



SOURCE: Urban Agenda Platform. Reverse vending machines.
https://www.urbanagendaplatform.org/best-practice/reverse-vending-machines

TURNING WASTEWATER INTO CLEAN ENERGY

LOCATION: South Sumatra, Indonesia

DATE: 2020 - ongoing

Biogas | Wastewater Management | Climate Action

PROJECT TITLE
Hamparan project

TARGET GROUP
Kırsal topluluklar, gıda işleme sektöründe çalışanlar, yerel hane halkları

PREVENTION LEVELS
Birincil Koruma

The Hamparan Project is an innovative biogas initiative implemented by Gree Energy in South Sumatra that aims to reduce the environmental and health risks caused by wastewater originating from the food industry. The project is built particularly on the treatment of industrial wastewater from cassava (manioc) starch production and the capture of the methane generated in this process to convert it into energy. The main objective is to reduce dependence on fossil fuels, produce clean energy, and improve the quality of life of local people together with environmental and economic benefits.

In Indonesia, more than 90% of food-sector producers lack modern wastewater treatment systems. This situation leads to greenhouse-gas emissions at a level comparable to the pollution generated by millions of people. In the specific case of cassava starch production, the wastewater produced daily by a single factory is equivalent to the pollution load of approximately 280,000 people. When this waste is discharged directly into the environment, it causes methane, a potent greenhouse gas, to be released into the atmosphere. Thanks to an anaerobic lagoon system, the Hamparan Project captures this methane and produces 11.5 million kWh of clean electricity per year. The energy produced is delivered via the national grid to households in 19 villages, thus providing rural communities with clean and reliable energy.

The project's implementation process has not only focused on energy production but has also established a multi-faceted structure that combines environmental and social benefits. According to 2023 data, the project has prevented 2,059 tons of CH_4 emissions and, on an annual basis, avoided 38,230 tons of CO_2e greenhouse-gas emissions. In addition, wastewater equivalent to a population of 251,535 has been treated, contributing to the protection of water resources. During biogas purification, desulfurization was carried out and 99.3% of H_2S gas was eliminated, preventing 4,162 tons of sulfur emissions. These results contribute directly to SDG 3 (Good Health and Well-being), SDG 6 (Clean Water and Sanitation), SDG 7 (Affordable and Clean Energy), and SDG 13 (Climate Action).

Social inclusion is one of the fundamental components of the project. Training and awareness-raising campaigns were organized for local communities, and awareness of sustainable waste management was developed. The participation of women and young people in the project has provided a strong gain in terms of social equality and has also supported local economic development. By taking active roles in implementation and project management, women have assumed leadership in communities' sustainable-energy processes.

One of the innovative aspects of the project is the valorization of by-products generated during biogas production through a circular-economy approach. As part of feasibility studies launched in 2023, steps were taken to convert treatment-plant sludge into organic fertilizer. Thanks to its high nutrient value and stable carbon content, this fertilizer is used in agricultural production, improves soil quality, and contributes to carbon sequestration. In this way, farmers' livelihoods have diversified and sustainable agricultural practices have been promoted. By collaborating with the civil-society organization Yayasan FIELD, the project provided US$100,000 in support to help farmers develop sustainable-living models.

The financing model is another element that strengthens the project's sustainability. Partnering with local communities, Gree Energy not only transferred technology but also handed over training, maintenance, and operating processes to local stakeholders. In this way, the project has gained a structure that is not dependent on external support and is owned locally.

In the long term, the impacts of the Hamparan Project are significant at both environmental and social levels. In terms of health, controlling wastewater has reduced the risks of infectious diseases and improved living conditions, especially for children and the elderly. From an environmental perspective, the reduction of carbon emissions, the prevention of deforestation, and the protection of water resources have created positive effects on the ecosystem.

From an economic perspective, the production of clean energy and the use of organic fertilizer have generated new income opportunities and expanded employment in the agriculture and energy sectors.

From a sustainability perspective, the Hamparan Project is more than a pilot application; it constitutes an exemplary model for the decarbonization of Indonesia's food-processing sector. Considering that more than 1,250 food-processing plants in the country lack modern treatment systems, scaling the Hamparan model makes it possible to prevent 50 million tons of CO_2e emissions annually and to produce 40 TWh of clean energy. This potential is directly aligned with Indonesia's commitments to increase the share of renewable energy to 34% and reduce carbon emissions by 32% by 2030.

SOURCES: Urban Agenda Platform. Hamparan Project.
https://www.urbanagendaplatform.org/best-practice/hamparan-project
Gree Energy.
https://gree-energy.com/

PERINATAL CLINICAL PSYCHOLOGY OBSERVATORY

LOCATION: Mozambique
DATE: 2021 - ongoing

Menstrual Health | Hygiene | Gender Norms | Adolescent Girls

PROJECT TITLE — Osservatorio Psicologia Clinica Perinatale
TARGET GROUP — Adolescent girls and young women
PREVENTION LEVELS — Primary Prevention

The Perinatal Clinical Psychology Observatory is a nationwide initiative that aims to protect mental health and increase psychological resilience in mothers and fathers during the prenatal and postnatal periods. By adapting the model that began in Italy in 2004 to the Mozambican context, the initiative has sought to prevent postpartum depression, strengthen the parent-infant bond, and safeguard early family health. The Observatory has not only focused on clinical interventions, it has also developed a holistic structure that includes research, training, monitoring, and community-based awareness activities.

The programme's focus has been the early identification of families at risk. Mothers and fathers at risk of perinatal depression undergo systematic screening, and psychosocial support and clinical referrals are provided where necessary. In this way, mental health problems are prevented at early stages before they become chronic, and parenting skills are strengthened. In this framework, group-based counselling sessions have been organized for families, supporting both individual and collective recovery processes.

The training component is one of the most important pillars of the initiative. In collaboration with the University of Brescia, postgraduate courses have provided capacity-building in perinatal clinical psychology for midwives, psychologists, and social workers. The skills of professionals who accompany the birth process have been enhanced to recognize psychological risks, strengthen the parent-infant bond, and make appropriate referrals. Thus, clinical knowledge has become applicable both within health institutions and directly in the field.

One of the initiative's most innovative methods has been Video Intervention Therapy (VIT). Parent-infant interactions are analysed through video recordings, and constructive feedback is provided to parents. This method has helped parents observe their own behaviours and develop positive interaction patterns. It has been an effective tool in strengthening the parent-child bond, especially among parents experiencing stress or at risk of depression.

The Observatory operates through a multidisciplinary structure. Psychologists, midwives, obstetricians, neonatologists, paediatricians, child neuropsychiatrists, and social workers are brought together on a common platform. This multi-stakeholder collaboration has strengthened the programme's sustainability. However, the greatest limitation has been a lack of funding. Budget constraints have made nationwide scaling difficult, yet effective models have been developed with existing resources, achieving significant successes at the local level.

By protecting the mental health of mothers and fathers during the perinatal period, reductions have been recorded in postpartum depression rates, and parent-infant bonds have been strengthened. These outcomes have not only improved families' quality of life but have also contributed to children's long term psychosocial development. Moreover, early intervention has reduced costs that the health system would otherwise have to bear in the future, contributing to social well-being.

The significance of this initiative lies not only in implementation but also in advancing perinatal psychology as an institutional field. Through university programmes, interdisciplinary collaborations, and innovative therapeutic methods, the Perinatal Clinical Psychology Observatory has become a model that can be emulated in Europe as well.

SOURCE: European Commission. Best practice 174.
https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/174

EMPOWERING GIRLS AND WOMEN FOR BETTER MENSTRUAL HEALTH

LOCATION: 72 Countries

DATE: 2014 - ongoing

Menstrual Health | Hygiene | Gender Norms | Adolescent Girls

PROJECT TITLE
Empowering girls and women to challenge harmful gender norms to improve menstrual health and hygiene, implemented as part of a WASH programme (UNICEF)

TARGET GROUP
Adolescent girls, young women, rural communities

PREVENTION LEVELS
Primary Prevention

Launched by UNICEF, the Menstrual Health and Hygiene (MHH) Programme is a global initiative aimed at addressing hygiene deficiencies and gender norms that directly affect the education of adolescent girls and young women. The programme began as a pilot in 2014 in 14 low- and middle-income countries and, as of 2019, has been implemented in 72 countries. This expansion underscores that menstrual health is not merely an individual matter but an important component of social equality.

The programme's core strategy is based on a human-centred design approach. Adolescent girls have been included not only as beneficiaries but also as active actors in the design and implementation of the programme. In this framework, mobile applications (for example, Oky in Indonesia), comics, and context-specific information materials have been developed across different countries.

In addition, women's participation in WASH committees has been encouraged, strengthening community-based decision-making processes.

The MHH programme is innovative in that it treats menstrual health not solely as a biological issue but as a field targeting the transformation of social norms. The construction of menstrual-friendly toilets in schools, the expansion of access points for safe water and sanitation, and the establishment of safe waste-management infrastructure have improved physical conditions. At the same time, low cost and reusable hygiene products have been developed, participation by local women entrepreneurs in these processes has also supported economic empowerment.

Data from pilot implementations show marked reductions in girls' absenteeism from school during menstruation.

The breaking of menstrual stigma has enabled more open discussion of the issue within communities, increased access to hygiene products has had positive effects on the health indicators and self-esteem of young women. In addition, the programme has encouraged the participation of male students and community leaders, making menstrual health a societal responsibility.

UNICEF's MHH programme aims to create a sustainable structure by integrating it into national health and education policies over the long term. The programme's future success depends on continuing infrastructure investments as well as on strengthening participatory methods that drive the transformation of social norms.

SOURCE: Gender and Health Hub. What works in gender and health.
https://www.genderhealthhub.org/wp-content/uploads/2021/12/What-works-in-Gender-and-Health_DIGITAL_Spreads.pdf

NATIONAL HPV VACCINATION PROGRAM

LOCATION: Australia
DATE: 2007 - ongoing

HPV Vaccine | Cervical Cancer | Immunization

PROJECT TITLE
TARGET GROUP
PREVENTION LEVELS

National Women's Health Strategy 2020-2030/National Human Papillomavirus (HPV) Vaccination Program
Adolescent girls and young women (later expanded to include boys)
Primary Prevention

With the National HPV Vaccination Program launched in 2007, Australia became one of the world's leading countries in this area. Cervical cancer has been identified as one of the most common and preventable diseases threatening women's health, proof that HPV is the principal cause of this cancer made implementation of a nationwide vaccination programme critical. This initiative aims to eliminate preventable causes that lead to the loss of young women's lives and to reduce the circulation of HPV in the wider community.

The primary design goal of the programme has been to ensure free access to the HPV vaccine for adolescent girls and young women. Therefore, vaccinations were initially delivered in schools, health workers operated directly within educational institutions to achieve high coverage rates. Over time, the programme was expanded to include boys as well. In this way, not only HPV-related health problems in women but also those in men could be prevented, and the circulation of the virus across society was significantly reduced.

This implementation is important both as a medical immunization initiative and as a public health policy that supports gender equality. Although the HPV vaccine was long seen as a health tool aimed only at women, the Australian approach, by including boys, has presented a more equitable and epidemiologically effective model. This has reduced stigma and facilitated acceptance of the vaccine.

The vaccination programme has not been limited to clinical implementation, it has also been supported by large-scale awareness campaigns. Through media channels, social platforms, and community-based events, families and young people have been reached and provided with comprehensive information on the importance of the vaccine. Campaigns conducted by health professionals, midwives and nurses, have built public trust and rapidly raised vaccination rates. Multilingual materials have been prepared, especially for migrant communities, to prevent cultural differences from becoming barriers to vaccine access.

The financing model has been provided through the federal health budget, with implementation carried out in cooperation with state health agencies. National health institutes and cancer research centres have strengthened the scientific basis of the programme, while screening and monitoring systems have continually evaluated the vaccine's impact. This holistic approach has secured not only the quantitative success of vaccination but also long term public health outcomes.

Within the first decade after implementation, dramatic decreases were observed in HPV infection rates among young women. The incidence of precursor lesions of cervical cancer fell significantly, and Australia gained global attention as one of the first countries to aim to eliminate cervical cancer as a public health problem. The World Health Organization has evaluated Australia's experience as a good practice globally. In addition, reduced circulation of HPV in the community has lowered the incidence of other HPV-related diseases, such as head-and-neck cancers.

The programme's social impact is also significant. Free, school based vaccination has helped overcome socio-economic inequalities, ensuring access to the vaccine for young women and men living in low income and rural areas. Moreover, increased public awareness has made HPV a more discussable topic, reduced stigma has made it easier, especially for young women, to seek health services.

Including the vaccine in the national immunization schedule has also strengthened preventive-health policies. In the long term, it is expected to reduce the high costs allocated to cervical-cancer treatment and to ease the burden on the health system. This would allow resources to be redirected more toward preventive-health services.

SOURCE: Australian Government, Department of Health. (2021). National women's health strategy 2020-2030. https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030_0.pdf

PREVENTION OF STILLBIRTHS AND PREGNANCY MONITORING

LOCATION: Australia

DATE: 2018 - ongoing

Awareness Campaign | Stillbirth | Risk Tracking | Pregnancy Monitoring

PROJECT TITLE
National Women's Health Strategy 2020-2030/National Women's Maternal, Sexual and Reproductive Health

TARGET GROUP
Pregnant women

PREVENTION LEVELS
Primary Prevention

The relatively high rates of stillbirth in Australia, particularly among disadvantaged groups and in rural areas, have been identified as a critical area for intervention within the national women's health strategy. Launched in 2018 with a federal investment of AUD 7.2 million, the programme was implemented to protect maternal and infant health, identify risk factors early, and improve the quality of antenatal care services. The strategy has adopted a multi-dimensional approach based not only on clinical practice but also on scientific research, public awareness, and policy design.

A key step has been the scientific investigation of risk factors. In this context, funds for perinatal-health research have been expanded, and studies increasing the use of biomarker analysis and ultrasound technologies have been supported. Multifaceted data, such as genetic predispositions, pregnancy complications, and lifestyle factors, have been integrated into national databases.

This process has strengthened evidence-based decision-making capacity among policymakers, laid the groundwork for updating clinical guidelines, and supported the preparation of new training materials for health professionals.

Another area of implementation has been nationwide awareness campaigns. Campaigns prepared particularly for women in their first pregnancies have emphasized the importance of early recognition of signs related to stillbirth risk. Reducing tobacco and alcohol use during pregnancy, not missing regular check-ups, and maintaining healthy nutrition have been central to the campaigns. Fathers and family members have been encouraged to take supportive roles, adopting an inclusive family approach that does not place health responsibility solely on the mother.

To reduce barriers to access in rural areas, mobile clinics and telehealth services have been introduced.

Here, however, telehealth has been structured solely for early diagnosis and the referral of high risk pregnancies to specialist centres. Through digital reporting systems, complications have been detected in a timely manner and cases monitored at the national level. These technology-based monitoring mechanisms have increased the continuity of pregnancy follow-up and helped health workers manage workloads more systematically.

The programme's effects have begun to be observed quickly. National health data indicate a significant reduction in stillbirth rates. Participation in pregnancy follow-up has increased, playing a critical role in reducing inequalities, especially in rural areas. Public-opinion research has shown that women are more aware of risks during the antenatal period and that their confidence in the health system has increased.

The programme's innovative dimension lies in its integration of scientific-research infrastructure with clinical practice. National-level databases have enabled the development of risk-tracking algorithms, building an information ecosystem that allows more accurate analysis of stillbirth causes. This structure also presents potential for future development of AI-supported early-warning systems.

Future plans include transforming this programme into a more comprehensive digital risk-management platform. In this way, the goal is to establish a national early-warning system for preventing not only stillbirths but all complications that may arise during pregnancy.

SOURCE: Australian Government, Department of Health. (2021). National women's health strategy 2020-2030. https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030_0.pdf

BREASTFEEDING AND MATERNAL SUPPORT PROGRAMME

LOCATION: Australia
DATE: 2019 - ongoing

Breastfeeding | Maternal Support | Perinatal Health

PROJECT TITLE
TARGET GROUP
PREVENTION LEVELS

National Women's Health Strategy 2020-2030/National Women's Maternal, Sexual and Reproductive Health
New mothers, infants, women living in rural areas, migrant and refugee women
Primary Prevention

Within the Australian National Women's Health Strategy 2020-2030, breastfeeding and maternal support have been identified as core priorities in protecting the health of women and infants. WHO data show that exclusive breastfeeding for the first six months after birth significantly reduces infant mortality and also lowers the risk of diabetes and certain cancers in mothers. However, socioeconomic and geographic differences in breastfeeding rates in Australia have made it necessary to develop equitable policies in this area. For this reason, the Australian National Breastfeeding Strategy 2019 and Beyond was implemented in 2019 and institutionalized at the national level.

The first step of the programme has been to enhance the competence of health professionals in breastfeeding. Specialized training modules have been prepared for midwives, nurses, and physicians, and the National Health and Medical Research Council, Infant Feeding Guidelines have been integrated as a core reference into clinical practice. Local health centres and family practices have been reorganized to provide one-to-one breastfeeding counselling for mothers in the postpartum period.

An innovative aspect of the programme is that it strengthens mothers' access not only to health services but also to social support networks.

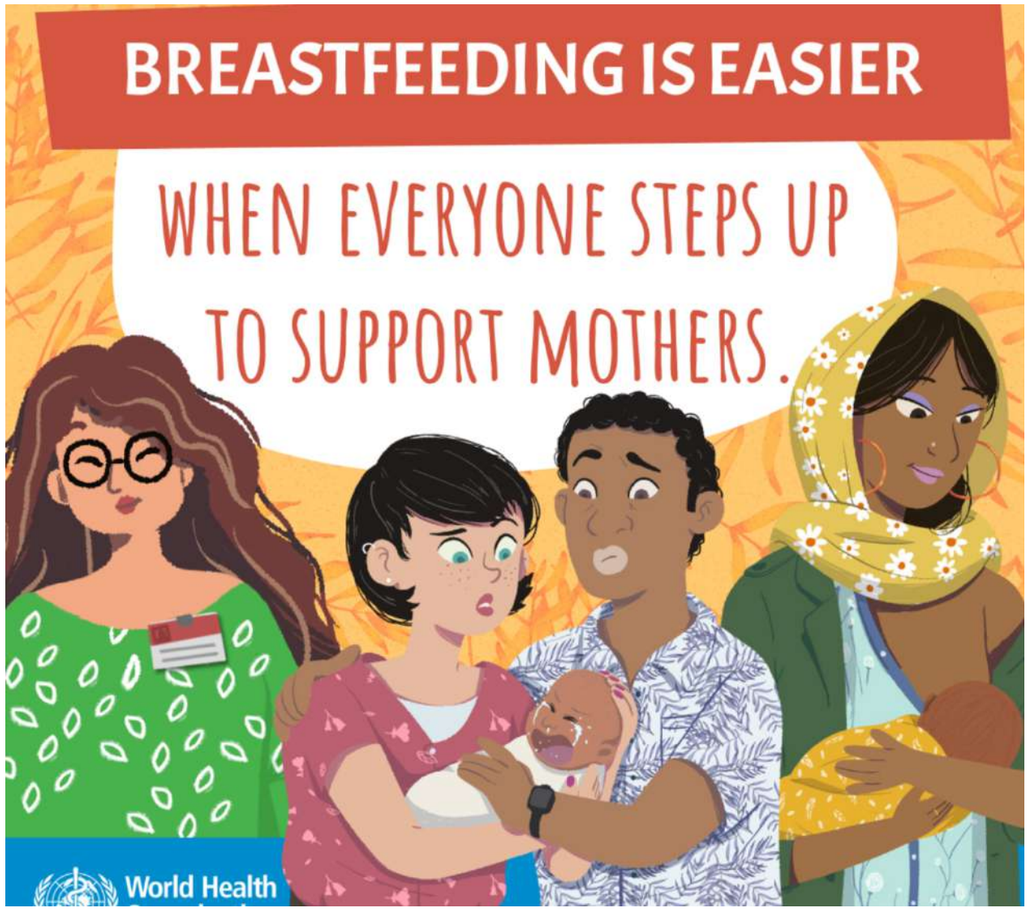
Community-based support groups, breastfeeding helplines, and peer-support systems composed of volunteer mothers have been activated. In this way, women have been supported medically as well as emotionally and socially. Digital platforms have complemented this process, enabling mothers to receive online counselling and share experiences.

Culturally safe service design has been prioritized especially for migrant, refugee, and Indigenous women. Multilingual information materials have been prepared, and visual, narrative-based training tools have been developed. Thus, language barriers and cultural differences have not been allowed to become obstacles to accessing breastfeeding support. The programme has adopted an inclusive approach that recognizes diversity within society.

The financing model has been provided through the federal health budget, with state governments contributing co-financing for infrastructure investments. Universities and NGOs have played active roles in awareness campaigns, while the private sector has contributed particularly by developing digital counselling and mobile-application solutions.

The programme's gains have quickly appeared in statistics. National-level measurements indicate an increase in the proportion of infants exclusively breastfed for the first six months. Feedback from mothers shows that they feel safer and more supported in the postpartum period. The programme's distinctive impact lies in its integration of community-based approaches that strengthen the mother-infant bond into the health system. Addressing breastfeeding not only as a biological feeding process but also as a social and psychosocial element of well-being has made the strategy exemplary internationally.

Future plans include making breastfeeding support a permanent national standard of care. In later phases of the strategy, the goal is to further integrate breastfeeding policies with digital-health strategies and to develop indicators that jointly monitor maternal well-being and infant health.



SOURCE: Australian Government, Department of Health. (2021). National women's health strategy 2020-2030. https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030_0.pdf

DIGITAL ASSISTED MONITORING FOR DIABETES

LOCATION: Apulia, Italy
DATE: 2017 - ongoing

Diabetes Management | Digital Health Technologies | Telemedicine

PROJECT TITLE — DIAMONDS-Digital Assisted Monitoring for Diabetes
TARGET GROUP — Patients with chronic diseases
PREVENTION LEVELS — Secondary Prevention

The DIAMONDS (Digital Assisted Monitoring for Diabetes) project is an innovative digital-health initiative designed to improve metabolic control among insulin-treated patients in the Apulia Region. The project addresses chronic problems such as incorrect blood-glucose measurements, follow-up frequencies that do not comply with guidelines, and erroneous data reporting. In diabetes therapy it is common to observe that HbA1c levels remain above 7 in more than 50% of patients and that adherence rates are only around 60%. Moreover, most hypoglycaemic and hyperglycaemic episodes occur when patients are alone, leading to serious, even life-threatening consequences.

In this context, the project enables patients to transmit their self-monitoring of blood glucose (SMBG) data in real time via telemedicine and web-based monitoring systems, to have them analysed, and to share them with physicians.

Rather than a single-purpose project, it is a multi-application linked to other subprojects concerning diabetes and complications such as nephropathy or cardiovascular disease. In this way, it aims not only to improve individual patient follow-up but also to increase the overall effectiveness of the health system.

Within the project, patients conduct measurements using smartphone-connected glucometers. During measurement they enter whether it is pre-prandial or post-prandial, and values are transmitted to a server supported by a Decision Support System (DSS). Algorithms analyse the data and provide feedback to both the patient and healthcare professionals. In emergencies (for example, glucose <40 mg/dL), the system automatically sends an SMS, if necessary, the healthcare team contacts the patient directly. Patients can also use DSS-provided automated algorithms to adjust insulin doses.

One of DIAMONDS' strongest features is its monitoring of guideline adherence. In this way, patients who measure at incorrect frequencies are quickly identified and interventions made where needed. The system also prevents erroneous data reporting (false records observed in 25-30% of cases). Providing patients with detailed glucose data strengthens adherence and enhances self-management skills. This structure makes the project easily modular and adaptable to different regions and patient groups.

The project budget is between €100,000 and €499,999, with core funding from private sources. Although it brings an additional cost of about €750 per patient per year, hospitalizations and treatment expenses are expected to fall significantly over the long term as complications decrease. For example, in the Apulia region, 10,362 hospital admissions for severe hypoglycaemia between 2002 and 2010 created costs of €31 million. In this context, savings generated by DIAMONDS are expected to offset costs.

Pilot studies and clinical trials have recorded significant reductions in HbA1c levels among patients using DIAMONDS. This indicates improved metabolic control and reduced risk of complications. The system has also enabled early detection of hypo- and hyperglycaemic episodes, accelerating emergency responses and improving patients' quality of life. Measurement appropriateness has increased, erroneous data reporting has been prevented, and patient-physician communication has intensified.

DIAMONDS has medium-term potential for high impact. The system has the capacity to transform diabetes management both at the individual level and in the context of health policy. Although it has a high level of transferability, it has not yet been deployed in other regions. Nevertheless, meetings with stakeholders (public authorities, glucometer manufacturers, patient associations) and shared reports indicate potential for national and European-level scaling in the future.

SOURCE: European Commission. Local policies for chronic diseases.
https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/137

POPULATION INTERVENTION PLAN FOR MULTIMORBIDITY

LOCATION: Basque Country, Spain

DATE: 2018 - ongoing

Multimorbidity | Integrated Care | Risk Stratification

PROJECT TITLE
Population Intervention Plan for Multimorbidity

TARGET GROUP
Patients with chronic diseases, health professionals, adults with multimorbidity, older adults with multimorbidity

PREVENTION LEVELS
Tertiary Prevention

The Population Intervention Plan (PIP MM) is an integrated-care model developed in the Basque Country to improve access and quality of care for vulnerable and older individuals living with multiple chronic diseases. Compared with those with a single chronic disease, individuals with multimorbidity account for approximately 49% of total health expenditures. This group is characterized by frequent hospital visits, risk of referral to care homes, and complex needs for social support. Because they often require multiple health professionals simultaneously, their treatment processes are fragmented, which increases costs and reduces quality of life. Therefore, the programme aims to abandon a disease-centred perspective and establish a patient-centred model, ensure continuity between health and social care, and enable care to be delivered in the most appropriate setting, preferably at home.

The plan reconfigures health-service delivery with a population-based approach. Shared care pathways, common goals, and indicators have been defined among professionals working at different levels of the health system. Developed through cooperation between clinicians and managers, the programme has produced an institutional model that defines new roles. Using risk-stratification tools, high risk patients are identified in advance, allowing personalization of treatment processes and preventing unnecessary hospitalizations. In the Basque health system, 33% of those with chronic conditions consume 70% of resources. Proactively identifying the 43,000 people living with multimorbidity is therefore critical for sustainability.

A strong ICT infrastructure plays a key role in the plan's success. Electronic Health Records, e-prescribing systems, and Personal Health Records have facilitated data sharing among professionals.

With telehealth and telecare applications, patients can be monitored at home, preventing emergencies. Primary-care physicians and nurses bear primary responsibility for designing care plans and for education, regular home visits and phone calls are used to monitor patients' status. In more complex cases, specialist physicians and hospital teams intervene. By defining roles such as "reference internist" and "hospital liaison nurse," communication between hospital and primary care has been strengthened.

Another aspect of the programme is that when patients' health deteriorates, the process is managed not only by treatment but also through early-warning and prevention strategies. Thanks to risk stratification, high resource consumers are identified early and care adapted to the individual. This approach has not only reduced costs but has also improved coordination of care by increasing collaboration among professionals. Telecare centres have supported patients even outside office hours, delivering health advice via nurses working from validated protocols. In this way, the system has shifted from reactive to proactive.

In terms of financing, the programme has been made a priority by the Basque Department of Health and linked with budget planning for service providers. This has encouraged active participation by managers and health professionals and has helped create a shared vision. Because patients with multimorbidity consume 49 times more resources than those with single diseases, the system's unsustainability has become a concern.

The programme is therefore considered a critical step both to control health expenditures and to increase patient satisfaction.

Implemented in the Basque Country, the Population Intervention Plan has initiated a profound transformation in the care of people with multimorbidity. Early identification of patients, the creation of personalized care pathways, and the use of a robust ICT infrastructure have improved both health outcomes and system efficiency. The programme has enhanced the quality of life of the target population and has become a model that can inform similar initiatives internationally.

SOURCE: European Commission. Chronic disease prevention initiatives. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/322

IRELAND'S PATH TO BECOMING TOBACCO-FREE

LOCATION: Ireland

DATE: 2017 - ongoing

Tobacco Control | Smoke-free Areas | Smoking Cessation Support Programmes

PROSPERITY | PEOPLE | PARTICIPATION | 3 GOOD HEALTH AND WELL-BEING | 10 REDUCED INEQUALITIES

PROJECT TITLE
Tobacco Free Ireland - Ireland's tobacco control policy and programme operating under the Healthy Ireland Framework for Health and Wellbeing 2013-2025

TARGET GROUP
General population

PREVENTION LEVELS
Primary Prevention

Published in 2013 within the Healthy Ireland Framework, Tobacco Free Ireland was designed as a comprehensive public health initiative aiming to reduce the national smoking rate to below 5% by 2025. Tobacco use, one of the principal causes of preventable diseases in Europe such as cardiovascular disease, stroke, and type 2 diabetes, is associated in Ireland with approximately 2,500 strokes and 500 stroke-related deaths each year, and adds around €500 million annually to health expenditures. The programme therefore aims not only to improve health outcomes but also to reduce socioeconomic inequalities and ensure sustainability within the health system.

Ireland has been a pioneer in tobacco control in Europe. In 2004 it became the first European country to ban smoking in all indoor workplaces, in 2012, during its Presidency of the Council of the European Union, it led the process for adopting the Tobacco Products Directive. Adopted in 2013, Tobacco Free Ireland includes multi-dimensional measures such as protecting children, preventing the normalization of smoking in society, strictly regulating the sale and marketing of tobacco products, increasing taxes, implementing standardised packaging, expanding smoke-free zones in both indoor and outdoor areas, and strengthening cessation support. In this context, a comprehensive national approach has been developed that encompasses all elements of the WHO MPOWER model.

One of the most important components of the implementation has been the QUIT campaign launched in 2014. Conducted at the national level, this campaign has informed the public with hard-hitting, emotional, and striking messages across television, social media, and online platforms, while providing multi-channel support to those who want to quit. Within QUIT, counselling teams provide free services by phone, email, web chat, and social media, and offer a standard cessation support programme extending over 12 months. The website QUIT.ie enables users to create independent quit plans, track progress, and access counsellors instantly. Since 2011, more than 600,000 quit attempts have been recorded, demonstrating the programme's reach.

The policy's socioeconomic dimension is also noteworthy. Because smoking is more prevalent and has more destructive effects in low income communities, campaigns have been designed particularly for these groups, access to nicotine-replacement therapies has been increased, and enforcement has been intensified in low income neighbourhoods. Using television and digital media rather than print has been effective in reaching youth and disadvantaged groups in media campaigns. This approach has been evaluated as a good practice by the European Commission.

The policy is implemented in cooperation with local governments and civil-society organizations. For example, municipalities have made children's playgrounds smoke-free, and smoke-free campus policies have been expanded in hospitals and health centres. Steps have also been taken to make public spaces such as universities, parks, and beaches smoke-free. These practices have removed smoking from everyday social life and strengthened the goal of "denormalisation."

Monitoring and evaluation are among the programme's strengths. Annual reports published by the Department of Health and the Health Service Executive (HSE) regularly document changes in smoking prevalence and the impact of interventions. According to the data, the smoking rate fell from 28.3% to 19.5% between 2003 and 2014. A significant decrease has also been recorded among children and adolescents, in 2014, the rate of smoking in the 10-17 age group fell to 8.3%. This shows that Ireland is among the fastest-moving countries in Europe with respect to its younger population.

The programme is financed directly by the Department of Health and implemented with strong institutional ownership. Political leadership has remained resolute regarding legislative measures and has staunchly defended the policy against legal challenges from the tobacco industry. In addition, the HSE has launched a Smoke-free Campus Policy in all hospitals and has developed training programmes for staff.

With its comprehensive and integrated structure, Tobacco Free Ireland is a model tobacco-control programme in Europe. Legislative measures, media campaigns, cessation support services, and smoke-free approaches in social spaces have created strong impacts at both individual and societal levels.

SOURCE: European Commission. Community health programs. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/50

HEALTHY LIFE CENTRES FOR COMMUNITY WELLBEING

LOCATION: Norway

DATE: 2017 - ongoing

Behaviour Change | Prevention of Non-communicable Diseases | Community-based Health Services

PLACE | PEOPLE | PARTICIPATION

3 GOOD HEALTH AND WELL-BEING | 4 QUALITY EDUCATION

PROJECT TITLE — Frisklivssentral

TARGET GROUP — General population

PREVENTION LEVELS — Primary Prevention

Healthy Life Centres (HLCs) are community-based health centres run by municipalities in Norway to help people adopt healthy lifestyle habits. The goal of these centres is to support individuals in preventing and managing non-communicable chronic diseases such as obesity, cardiovascular disease, diabetes, cancer, and respiratory conditions. In addition to exercise groups, healthy-eating counselling, and smoking-cessation support, centres provide guidance on sleep, mental health, and alcohol use.

In Norway, approximately 30% of deaths under the age of 75 are due to chronic diseases. According to 2009 data, 40% of these deaths were due to cancer, 20% to cardiovascular disease, 4% to respiratory conditions, and 2% to diabetes. While there have been substantial declines in cancer and cardiovascular mortality over the last 30 years, the rapid rise in obesity rates has shown the need for new preventive strategies.

The first implementation of Healthy Life Centres began in Modum Municipality in 1996. The "green prescription" programme for people with diabetes and hypertension in 2003 was developed through pilots between 2004 and 2011. In 2011, the Norwegian Directorate of Health defined these centres within the national health system, with the Public Health Act enacted in 2012, all municipalities were recommended to establish centres. By 2015, more than 220 centres had been opened, although nationwide coverage across all municipalities had not yet been achieved.

Participants typically enrol in a 12-week programme at the centres. During this period, individual consultations are held, personalized goals are set, and people are referred to groups for exercise, nutrition, or smoking cessation. Where necessary, programme duration can be extended. "Motivational Interviewing" is one of the principal methods used. This approach aims to make behaviour change permanent by activating an individual's internal motivation.

Healthy Life Centres are not only a component of the health system, they also work closely with the community. By collaborating with municipalities, hospitals, universities, NGOs, and the private sector, they connect people to local activities. Thus, individuals can maintain healthy lifestyle habits even after they leave the programme. By including vulnerable groups, such as those who do not attend fitness centres or face financial barriers, the centres reduce health inequalities.

The centres are publicly funded. While the programmes were initially supported by the Ministry of Health, they were later integrated into municipal budgets. A range of professionals, physiotherapists, dietitians, nurses, trainers, and occupational therapists, work together to provide comprehensive services.

Evaluations show that Healthy Life Centres produce lasting results particularly in increasing physical activity, improving dietary habits, and supporting smoking cessation. A review by the Norwegian Knowledge Centre has shown that these centres are cost effective. For example, the social welfare benefits generated by individuals who exercise regularly and do not smoke are valued at millions of Norwegian kroner. For this reason, Healthy Life Centres provide significant contributions at both individual and societal levels.

Healthy Life Centres have become a key instrument in Norway's strategy for combating chronic diseases. Accessible at the local level, person-centred, and grounded in scientific methods, these centres offer an effective model for developing health behaviours and reducing health inequalities.

SOURCE: European Commission. Health promotion in chronic care. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/68

THERAPEUTIC HORTICULTURE FOR AN AGEING POPULATION

LOCATION: Singapore
DATE: 2020 - ongoing

Older-adult Health | Therapeutic Horticulture | Care farming | Social Inclusion

PROJECT TITLE
TARGET GROUP
PREVENTION LEVELS

Therapeutic Horticulture
Older adults, people living with dementia, individuals on the autism spectrum, low income older adults, at-risk communities
Tertiary Prevention

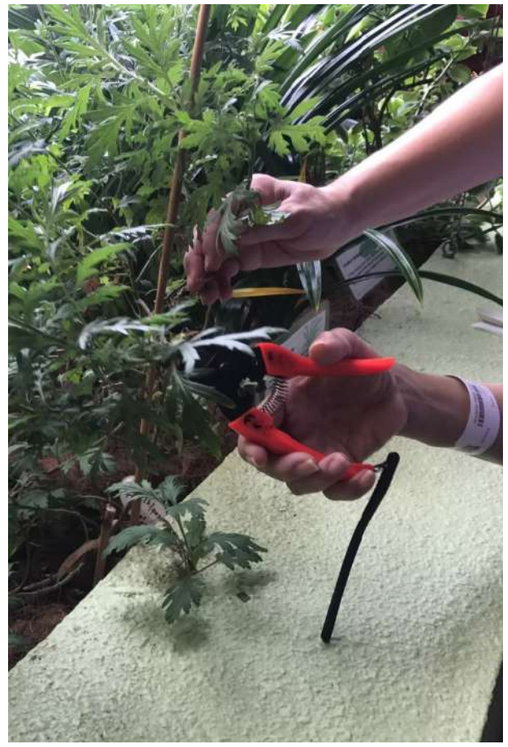
The Care Farming and Therapeutic Horticulture initiative implemented in Singapore has been developed as a holistic response to the health and social-care needs arising from a rapidly ageing population. It is projected that by 2030 the number of people aged 65 and over in the country will reach 1 million, cases of dementia will increase, and annual care costs will rise to 49 billion dollars. This picture has made it necessary to develop new care models that support the independence of older adults and strengthen social solidarity.

The project conceptualizes horticulture not merely as a hobby or production activity but as a therapeutic tool with direct effects on physical, cognitive, and mental health. In alignment with Singapore's "30 by 30" food-security strategy, local production is encouraged while the production process is transformed into a rehabilitation setting for older adults and vulnerable groups.

Research conducted with the National University of Singapore and the National Parks Board has found that people with early-stage dementia experience positive developments in memory, motor skills, and mental health through gardening activities. Older adults and low income individuals participating in the programmes have strengthened their social ties, and inclusive learning environments have been created for individuals on the autism spectrum.

One of the innovative aspects is the community-scale implementation of horticulture through a "care farming" model. In programmes run with the Montfort Care Centre, particularly at-risk older men have been involved in production processes, as a result, their social isolation has decreased and independent living skills have been strengthened. The programme has promoted psychological recovery, stronger social bonds, and the spread of awareness of sustainable agriculture.

The project has not been limited to older adults, therapeutic-horticulture programmes have also been organized for stressed office workers, at-risk youth, and incarcerated people. In this way, the scope of rehabilitation has been expanded and horticulture has become a common space of recovery for different social groups. The financing model also includes making the knowledge and experience gained open-source, enabling transfer of the practice to other cities facing similar challenges. Producing crops with high nutritional value has strengthened the project's structure that integrates food security with public health.



SOURCES: Urban Agenda Platform. Care farming and therapeutic horticulture.
https://www.urbanagendaplatform.org/best-practice/care-farming-and-therapeutic-horticulture
Edible Garden City. Therapeutic horticulture.
https://www.ediblegardencity.com/therapeutic-horticulture

REINTEGRATION THROUGH SPORT

LOCATION: Greece

DATE: 2016 - ongoing

Sport Therapy | Addiction Rehabilitation | Social Integration

PROJECT TITLE
KETHEA-Reintegration Through Sport

TARGET GROUP
Individuals receiving treatment for substance use disorder (SUD), health professionals, sports-science students, civil-society organizations

PREVENTION LEVELS
Tertiary Prevention

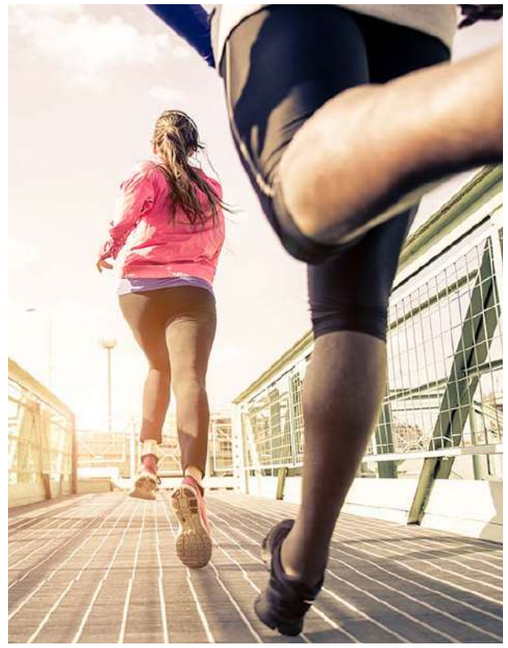
Reintegration Through Sport (RTS) is an innovative initiative in Greece that integrates sport into the rehabilitation of individuals living with substance use disorder. Because substance dependence has social and economic dimensions in addition to medical aspects, the RTS model uses sport as both a treatment tool and a means of social reintegration.

Through regular exercise, team sports, and activities focused on personal development, the programme helps participants build self-confidence, develop healthy behaviour patterns, and reconnect with society. This therapeutic role of sport has provided a significant complementary contribution to classical treatment approaches.

Training programmes have also been organized for health professionals under the project, increasing their capacity to integrate sport into addiction treatment. These trainings include both theoretical knowledge and practical methods, enabling health workers to develop personalized sport-based treatment plans.

RTS is financed by the Erasmus+ Programme and is considered a model applicable across Europe. Participants have shown increased motivation for sport, improvements in physical and psychological health, and accelerated social integration processes. Some participants have transferred the gains sport brought into their daily lives, strengthening the durability of rehabilitation.

The results show that sport is a powerful tool not only for physical health but also for behaviour change and social cohesion. Thanks to group dynamics, social bonds have been strengthened, self-confidence has increased, and motivation has been maintained during the rehabilitation process. In the long term, the project is expected to enhance cooperation between health and sports institutions and strengthen multidisciplinary approaches to combating addiction.



SOURCE: European Commission. Mental health promotion programs.
https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/443

STRENGTHENING MENTAL HEALTH THROUGH NARRATIVE THERAPY

LOCATION: London, United Kingdom

DATE: 2014 - 2016

Perinatal Psychology | Prevention of Depression | Resilience-building | Patient-staff Relationship

PROJECT TITLE
SLaM (South London and Maudsley NHS Foundation Trust) 'Tree of Life' approach

TARGET GROUP
Adults experiencing mental health difficulties, individuals with learning difficulties and disabilities, older adults

PREVENTION LEVELS
Secondary Prevention

Developed by the South London and Maudsley (SLaM) NHS Foundation Trust, the "Tree of Life" approach is an innovative narrative-therapy programme that aims to strengthen patient-staff relationships in mental health services and improve preparation for discharge. This method enables individuals to share strengths, hopes, and positive experiences in their lives rather than focusing solely on traumas they have experienced.

The starting point of the programme was to develop a culture of trust, empathy, and collaboration in clinical settings. In this direction, 10 people who had previously benefited from mental health services received special training and took on facilitation roles in workshops. Thus, alongside professional staff, patients had the opportunity to receive support from people with similar lived experience.

In the workshops, participants express their personal stories through a "tree" metaphor. Roots symbolize the past, the trunk represents skills, branches denote hopes, and leaves stand for the people they value in their lives. At the end of the process, the drawings are brought together to form a "forest." This collective metaphor increases the sense of belonging and helps individuals see themselves not merely as "patients" but as multi-dimensional people.

Between 2014 and 2016 the programme was implemented in 16 psychiatric wards and intensive care units in South London, reaching more than 450 patients and 230 health workers. Evaluations show that 89% of participants viewed the programme positively. In addition, empathy, equality, and trust elements in clinicians' approach to care were strengthened.

Some clinics reported a reduction in patient complaints, increased treatment adherence, and a more positive social climate on the wards.

Initial funding was provided by the Maudsley Charity and later continued by the SLaM Foundation. Transferability of the method is high, indeed, it has been adapted and used in different contexts in Norway, Sweden, and Australia. This demonstrates that the model can be readily adapted to cultural contexts.

One of the strengths of the programme is that it makes participants active parts of the process. Patients are seen not only as people receiving treatment but also as members of the community who can contribute to others. This approach has brought the roles of health workers to a more humane dimension and has made mental health services more inclusive.

SOURCE: European Commission. Community-based disease management. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/85

REFLECTIONS OF HEALTH

LOCATION: Milan, Italy

DATE: 2013 - ongoing

Perinatal Psychology | Prevention of Depression | Resilience-building | Psychosocial Support

PROJECT TITLE — Salute allo Specchio

TARGET GROUP — Women undergoing cancer treatment

PREVENTION LEVELS — Tertiary Prevention

Launched in 2013 through collaboration between San Raffaele Hospital in Milan and the association Salute allo Specchio Onlus, "Salute allo Specchio" is an innovative psychosocial health programme aimed at developing holistic solutions to the physical and psychological challenges faced by women undergoing cancer treatment. Hair loss, skin problems, and changes in body image during treatment can cause serious psychological distress in women and increase the risk of depression, anxiety, and social isolation. The project aims to prevent these problems, rebuild women's self-esteem, and help them gain psychological resilience during treatment.

A key feature of the programme is its integrated structure combining implementation with research. In group sessions, psychologists, oncologists, volunteers, and specialists in oncological cosmetology work together, offering aesthetic supports such as make-up, wigs, skin care, and massage. In addition, psycho-education sessions are held on topics such as nutrition, fertility, sexuality, and family communication.

Through these activities, women experience improvements not only in physical appearance but also in mental health.

One of the strongest aspects of the programme is strengthening women's social bonds. Bringing together people with similar experiences has increased the feeling of being "understood" and reinforced solidarity. The group setting has created an opportunity not only to receive support but also to provide support to others. In this respect, the project has transformed individuals from passive patients into active subjects. Positive effects have also been observed in family communication, with support provided to mothers, in particular, in sensitive processes such as explaining a cancer diagnosis to children.

Research findings reveal the programme's concrete impacts. Significant reductions have been observed in levels of depression and anxiety, increases have been recorded in self-esteem and quality of life.

Most participants reported feeling less isolated and more valued by healthcare staff. These outcomes show that psychosocial support mechanisms are as critical as medical treatment.

The programme's holistic approach has helped women redefine their identities and their relationship with their bodies during treatment. Psychological counselling combined with aesthetic support has enabled patients to accept their body image and feel strong again. Participants' statements show that this support has a transformative effect not only on appearance but also on the broader meaning of life.

However, there are obstacles to scaling the project. One of the biggest challenges is lack of funding. The fact that psychosocial support is still regarded as a "complementary" service in many health systems makes it difficult to expand such programmes. Experts emphasize that these services should become part of standard treatment protocols so that they can secure a permanent and sustainable place in national health systems.

As of today, the programme is being conducted locally within San Raffaele Hospital in Milan. Nevertheless, the positive results obtained in the international literature show that the model can be adapted for other countries.

The programme demonstrates that psychosocial support should play a central role in health policies aimed at reducing the psychological burdens women experience during treatment.

salute allo specchio

SOURCE: European Commission. Healthy lifestyle interventions. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/155

DIGITAL SELF-MANAGEMENT TOOL FOR DEPRESSION

LOCATION: International (headquartered in Germany, coordinated by EAAD)
DATE: 2011 - ongoing

Digital Health | Cognitive Behavioural Therapy | Self-management | Psychosocial Support

PROJECT TITLE — iFightDepression-European Alliance Against Depression
TARGET GROUP — Adults and adolescents experiencing mild to moderate depression
PREVENTION LEVELS — Primary Prevention

iFightDepression is an innovative digital self-management tool developed by the European Alliance Against Depression (EAAD) for individuals living with depression. Depression is one of the most common mental health problems worldwide, affecting approximately 280 million people and leading to serious societal consequences ranging from loss of workforce to suicide. When not treated early, it deeply affects not only individuals' quality of life but also society's general well-being. iFightDepression was developed in response to this problem, making evidence based cognitive behavioural therapy (CBT) methods accessible via a digital platform.

The application is built around six modules. In these modules, users learn to understand the thought-emotion-behaviour relationship, recognize negative thoughts, plan daily activities, improve sleep hygiene, reduce stress and anxiety, and maintain healthy lifestyle habits. Participants can connect to the online system and complete these modules at their own pace.

What distinguishes iFightDepression from other digital tools is that the process must be conducted under the supervision of a health professional. Physicians, psychologists, or psychiatrists who complete special training provided by the EAAD are authorized to guide users. In this way, the application becomes a personalized support tool with high safety standards.

One of the programme's innovative aspects is its multilingual and culturally adaptable structure. Today it is available in more than 15 languages and offers content adapted to different cultural contexts. In the special version for adolescents, topics such as social anxieties, school based stressors, and peer relationships are emphasized. Thus, it provides an inclusive support tool for both adults and young people. It also offers an important solution for individuals living in rural areas or with limited access to face to face therapy.

Initial financing was provided through the European Union's PREDI-NU project (2011-2014). During this period, the software was developed, pilots were conducted, and initial user feedback was collected. The programme later became permanent under EAAD and was scaled up in cooperation with health ministries, universities, and civil-society organizations in different countries. EU funding programmes such as Horizon 2020 have also supported the scaling of local implementations. Thus, beyond individual use, iFightDepression has become recognized across Europe as part of community-based interventions.

Clinical research reveals the tool's tangible benefits. Significant reductions have been observed in participants' depressive symptoms, with increased self-management skills. More than 70% of users have successfully completed all modules, and 80% have regularly used mood-monitoring tools. Adolescent users in particular have reported positive outcomes in school achievement and social relationships. The combination of professional support and digital modules has offered a lower-cost yet similarly effective option compared to face to face therapies.

During the COVID-19 pandemic, the importance of iFightDepression increased further. With quarantine and social isolation, the need for online mental health support surged, and the number of users multiplied in a short time. The programme provided reliable and accessible support especially for individuals facing access barriers.

In conclusion, iFightDepression stands out as one of the most successful applications of digitalization in the field of mental health. While making it easier for individuals to cope with depression, it also provides an effective support tool for health professionals. With its low cost, reliable, and culturally adaptable structure, it produces effective solutions at both individual and societal levels. In the coming period, it is planned to be implemented in more countries, enriched with new modules for different age groups, and integrated into suicide-prevention strategies.

iFightDepression®
european alliance against depression

SOURCES: European Alliance Against Depression.
https://eaad-best.eu/
iFight Depression.
https://ifightdepression.com/en/

SUPPORTING FAMILIES AFFECTED BY PARENTAL MENTAL HEALTH ISSUES

LOCATION: Finland

DATE: 2001 - ongoing

Child Resilience | Family-based Intervention | Early Support | Psychosocial Methods

PROJECT TITLE
Let's Talk about Children

TARGET GROUP
Children of parents with mental health problems, teachers, social-service and health professionals

PREVENTION LEVELS
Primary Prevention

Launched in Finland in 2001 and continued to this day, "Let's Talk about Children" (LTC) is a short, family-based psychosocial intervention model. The programme's main aim is to protect the children of parents with mental health problems, reduce their developmental risks, and strengthen intra-family communication. Because mental health problems deeply affect the individual and family structure, it is critically important to support children emotionally and socially. At this point, LTC offers an evidence-based model to increase children's resilience and connect families with stronger support systems.

The programme is built on a two-phase structure. In the first phase, structured interviews are conducted with parents. In these interviews, the child's strengths, the challenges faced in daily life, and areas of needed support are identified. A feasible support plan is prepared together with the parents. In the second phase, when necessary, broader LTC network meetings are organized that include schools as well as health and social-service institutions.

In this way, a holistic support network is provided for the child not only within the family but also through the education and health systems.

One of the model's strengths is that it can be readily implemented across sectors. It can be used with standardized tools by teachers in education, by clinicians in health care, and by specialist staff in social services. The process is conducted transparently with standardized monitoring logbooks. Thus, the child's needs, decisions taken, and practices implemented are clearly recorded. In Finland the programme has been tried across different age groups from pre-school to upper secondary school and has been adopted with high satisfaction rates.

Research indicates that the LTC model reduces referrals to child-protection services, increases school success, and strengthens overall mental health. Children have been observed to be more resilient in social relationships and daily life, and parents have become better at recognizing their children's needs.

The programme has also enabled parents to talk about their own mental health problems with their children in a healthy way, increasing the sense of trust within the family.

In recent years the programme has spread across Europe. Under the EU4Health Programme, it has been adapted to eight different countries and is beginning to be accepted as a standard approach in early intervention. Its sustainability is ensured through MIELI Finland's national trainer network. Capacity is continually expanded as new professionals join training each year. Thus, the model has become a scalable prevention tool in Finland and other European countries.

One of the programme's most important effects is the early detection of mental health risks during children's developmental processes. Thanks to early-support mechanisms, potential psychological problems are prevented before they progress, and children are supported to grow up within a healthy social environment. In addition, the family-focused approach helps parents feel they are not alone and contributes to strengthening the relationship they establish with their children. Coordination among teachers, health workers, and social-service professionals creates a culture of community-based solidarity.

The financing structure is largely based on public resources. The Finnish government provides long term support for such programmes to encourage preventive approaches in mental health services. International funds and EU-supported projects have also enabled transfer of LTC to other countries.

When the results are evaluated, "Let's Talk about Children" offers an effective example of a preventive intervention at both individual and societal levels. By increasing children's resilience, strengthening intra-family communication, and ensuring coordination among social institutions, it produces long term benefits. For this reason, the programme is seen as a good practice model that can be adapted not only in Finland but also in other countries.

SOURCE: Mieli. The effective child and family work: Let's talk about children.
https://mieli.fi/en/front-page/society-and-advocacy/the-effective-child-and-family-work/lets-talk-about-children/

OPEN-SOURCE DIGITAL PLATFORM FOR HEALTH SYSTEM TRANSPARENCY

LOCATION: Pacific Island Countries (Solomon Islands, Tonga, Kiribati, Tokelau, Vanuatu, Cook Islands)

DATE: 2017 - ongoing

Open Source | Health Information Systems | Data Visualization | Resource Allocation

PROJECT TITLE
Tupaia

TARGET GROUP
Health-system managers, health workers, donors, local communities

PREVENTION LEVELS
Secondary Prevention

The Tupaia Project is an open-source digital monitoring and decision-support platform developed to increase visibility and transparency in health systems in the Pacific Island Countries. This project addresses the inadequacy of health infrastructure, data gaps, vulnerability to disasters, and difficulties in equitable resource allocation, especially in small island states such as the Solomon Islands, Tonga, Kiribati, Tokelau, Vanuatu, and the Cook Islands. Distances between health facilities, transportation challenges, and limited human resources in island countries severely restrict the effectiveness of public health services. In response to these problems, Tupaia was designed to geographically map the capacity of different health facilities from clinics to hospitals, visualize existing data, and build a system usable by decision-makers. Although it started as a single pilot, it rapidly expanded to a multi-country scale and became an internationally recognized programme.

In the implementation steps, data collected from health facilities were first transferred to the digital platform, and core indicators such as infrastructure status, access to clean water and sanitation, human resources, and medicine and supply stocks were compiled in a standardized format. In this process, different data sources such as DHIS2, mSupply, Tamanu, and Tupaia MediTrak were integrated under one roof. The collected data were visualized on maps using geographic information systems and presented to decision-makers through a user friendly interface. Deficiencies in facilities or issues requiring urgent intervention were quickly identified thanks to this platform, for example, which hospitals were damaged after tropical storms were reported within 48 to 72 hours, enabling rapid response. Tupaia also developed the mSupply Mobile module that allows health workers to track stock via mobile devices and successfully deployed this application especially in rural and remote areas.

One of the most striking aspects of the project is its innovative and adaptable structure. While traditional health information systems are often closed and centralized, Tupaia provided an open-source infrastructure that can be customized according to local conditions. Local health workers were included in the process not only as data providers but also as users of the system. In this way, data flows became functional not only top-down but also horizontally. In addition, professional networks established via communication tools such as Telegram enabled health workers to communicate in real time on issues such as supply shortages, patient referrals, or software problems, with thousands of messages exchanged monthly, these networks turned into strong support mechanisms.

In terms of financing and support, the project was initially supported by the Australian Government's innovationXchange programme and later expanded with international actors such as the World Bank, WHO, UNICEF, and the Bill & Melinda Gates Foundation. This multi-stakeholder financing model not only ensured financial sustainability but also allowed different areas of expertise to be integrated into the project. Moreover, the project's open-source nature eliminated licensing costs for implementation in new countries, increasing accessibility.

In terms of outcomes, Tupaia has provided significant contributions to regional health systems. In Kiribati, the medicine availability rate increased from 58% to 72% in one year, and stock management became more transparent and effective.

After Cyclone Gita in Tonga, damaged facilities were rapidly identified, thereby accelerating humanitarian interventions and reducing costs. The long-standing problem of "data invisibility" in Pacific health systems was largely resolved through this platform, leaving decision-makers with reliable, up-to-date, and geographically contextualized information. This has made health planning more equitable, efficient, and evidence-based.

From a future perspective, it is aimed that Tupaia will extend beyond health data and include environmental and social indicators as well. In this way, it could become an integrated planning tool in areas such as disasters caused by climate change, water and sanitation problems, and even education and social services. The project's adaptable structure facilitates transfer to different geographies and provides a model for low- and middle-income countries facing similar problems.

SOURCE: United Nations.Tupaia programme.
https://sdgs.un.org/partnerships/tupaia

DIGITAL HEALTH AND SELF-MANAGEMENT PLATFORM FOR 50+

LOCATION: Scotland, United Kingdom
DATE: 2013 - ongoing

Digital Health | Self-management | Social Participation | Well-being in Older Age

PROJECT TITLE — Living it Up
TARGET GROUP — People aged 50 and over, individuals with chronic conditions, carers
PREVENTION LEVELS — Primary Prevention

Living it Up (LiU) is an award-winning digital self-management platform developed in Scotland to support people aged 50 and over in better managing their health and quality of life. An ageing population and the increasing burden of chronic disease create substantial cost pressures for health systems. In Scotland in particular, a significant proportion of the population lives with long term conditions, increasing both social-care and health expenditures. In this context, LiU aims to empower citizens with digital solutions, enabling health services to be delivered more effectively and sustainably. Although the project started as a single initiative, it became part of the national digital-platform work of the Technology Enabled Care (TEC) Programme launched in 2014.

LiU's development process was carried out through a co-design approach with the public sector, private sector, voluntary organizations, and health workers. One of the most innovative aspects of the project is the direct involvement of users in the design process. The platform's tools, visual design, and content were developed together with the citizens who constitute the target group. Thus, the system has been able to offer solutions based on users' real needs that can be easily integrated into their daily lives. The project's technical infrastructure was built on Microsoft Azure and cloud services and developed with the support of industry partners such as ATOS, Sitekit, Maverick TV, Intrelate, and StormID.

LiU primarily provides solutions in three areas: self-management of chronic conditions, increased social participation, and the spread of preventive health practices. Access to information has been facilitated via digital tools especially for individuals with long term conditions and for family members who care for them. Users can access tele-health services through the platform, obtain information about local community services, and strengthen their health routines with lifestyle recommendations.

At the same time, the platform has a structure that strengthens social connections beyond the health focus. By providing information about local events, volunteering opportunities, and community activities, it reduces the risks of loneliness and isolation.

In terms of financing, the project has largely been supported by national resources, with a total budget in the range of €1-5 million. Reaching approximately 10,000-99,000 people, the project has delivered significant cost effective results at a cost of £1 to £2.80 per user. Independent evaluations have revealed that LiU users use health services three times less, participate in community volunteering six times more, and are more open to trying new self-management methods.

The results are strong not only at the individual level but also for the health system. The project has increased citizens' preventive-health habits, encouraged healthier nutrition choices, and promoted the development of more resilient coping strategies in care processes. In addition, Social Return on Investment (SROI) calculations show that each investment generated 37% public value. LiU's sustainable impact manifests in users becoming more informed and independent in the daily management of their health.

However, the project is still implemented only in certain areas. Wider national scale-up requires more local partnerships and resource support. Nevertheless, LiU is considered a strong example of how digital health solutions can play a transformative role in community-based care. In the long term, it is possible to transfer this model to other countries, although to date there has not yet been an international-scale transfer.

SOURCES: European Commission. School-based health initiatives.
https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/117
McNaughton, D. Living it up.
https://davidmcnaughton.co/living-it-up

INCOME GENERATING ACTIVITY AND LIFE PLANNING PROGRAMME

LOCATION: Luwero District (Uganda), Homa Bay County (Kenya)

DATE: 2016 - ongoing

Income-generating Activities | Life Planning | Youth Empowerment | Post-HIV/AIDS Support

PROJECT TITLE
Income Generating Activity and Life Planning Program to Support AIDS Orphans to Contribute to SDGs Goal 1, 3, 4 and 5

TARGET GROUP
HIV-positive single mothers, AIDS orphans, adolescent girls and young women

PREVENTION LEVELS
Secondary Prevention

The project has been designed to support AIDS orphans and HIV-positive single mothers, one of the most severe social and economic consequences of HIV/AIDS in Sub-Saharan Africa. There are more than 12 million AIDS orphans worldwide, and the vast majority of these children live on the African continent. The struggles of mothers living with HIV, poverty, social exclusion, and health problems, seriously hinder their children's continuation in education and the building of a healthy future. This problem has critical consequences both at the individual level and for social development. The core purpose underlying the programme is to improve the living conditions of these vulnerable families, protect children's right to education, and develop sustainable solutions that will provide mothers with economic independence. Rather than being a single project, it is a multi-component implementation conducted simultaneously in Uganda and Kenya.

Implementation steps have been developed and adapted to the needs of different communities. In the initiative launched in Uganda's Luwero District, the "Income Generating Activities (IGA)" model has been adopted to enable mothers to establish small businesses of their own. In this model, women have been encouraged to operate small cafés or stalls to obtain regular income. Part of the earnings is saved, and the other part is used for children's school expenses and basic needs. In addition, mothers have been provided training on establishing kitchen gardens, healthy nutrition, and life skills for living with HIV. In Kenya's Homa Bay County, a "Life Planning Programme" has been developed, here, career counselling sessions have been organized for youth. In this programme, conducted with about thirty households per year, children's motivation for education has been increased and they have been supported to set concrete goals for the future. At the same time, sustainable agricultural practices have been implemented using agroforestry methods, thereby both diversifying household incomes and increasing environmental resilience.

The most innovative aspect of the programme is the combination of income support and educational interventions. Unlike standard social-assistance models, not only short term cash support is provided but also a sustainable economic model has been developed whereby mothers can run their own businesses. In addition, the active role of youth in career planning stands out as an important aspect that differentiates it from classical scholarship programmes. Local communities, NGOs, health centres, child offices, and agricultural units have been integrated into the process as implementing partners of the programme. This broad participatory structure has strengthened the adaptability of the programme to different regions.

In terms of financing and support, the programme is based on local and international collaborations. The budget of the implementation has been created through contributions from civil-society organizations and support from regional development funds. In Uganda, micro-credit-like support has been provided for small businesses, while in Kenya technical support has been obtained from local agricultural offices for agroforestry implementations. Universities and research institutions have also taken part in impact evaluation, contributing to the programme's evidence-based progress.

The programme's outcomes have yielded measurable benefits in a short time. In Uganda, 80% of the households included in the programme began to obtain regular income, and a significant decrease was recorded in school dropout rates among children. In Kenya, 70% of the youth participating in life-planning sessions continued their education, and some were directed to vocational-skills courses.

Thanks to nutrition training and kitchen gardens, household food security increased, and improvements were observed in the health management of mothers living with HIV. From a socio-economic perspective, there has been an increase in families' self-worth and a strengthening of social-solidarity bonds.

The project's effects have not been limited to participating households. Agroforestry-based agricultural practices have supported surrounding ecosystems, increasing soil fertility and water-retention capacity. Thus, the programme has made important contributions in terms of both humanitarian and environmental sustainability. From a future perspective, it is planned that the model be expanded on a regional scale and integrated into national social-policy programmes. The successes in Uganda and Kenya are of a nature that will inspire other African countries experiencing similar problems.

SOURCE: United Nations. Income generating activity and life planning programme supports AIDS orphans. https://sdgs.un.org/partnerships/income-generating-activity-and-life-planning-program-support-aids-orphans-contribute

COLLABORATIVE COMMISSIONING OF CARE AT HOME SERVICES

LOCATION: Highland Region, Scotland (United Kingdom)

DATE: 2012 - ongoing

Care at Home | Collaborative Commissioning | Rural Health Services | Social-care Integration

PROJECT TITLE
Collaborative Commissioning of Care at Home Services

TARGET GROUP
Older people, individuals with chronic conditions, people in need of care living in rural areas

PREVENTION LEVELS
Primary Prevention

This initiative, launched by NHS Highland in the Highland region, is an innovative model that aims to integrate health and social-care services holistically to respond to the increasing needs of an ageing population. The core objective of the implementation is to make care-at-home services more accessible, sustainable, and high quality, especially so that older people and those with chronic conditions can maintain independent living after discharge from hospital.

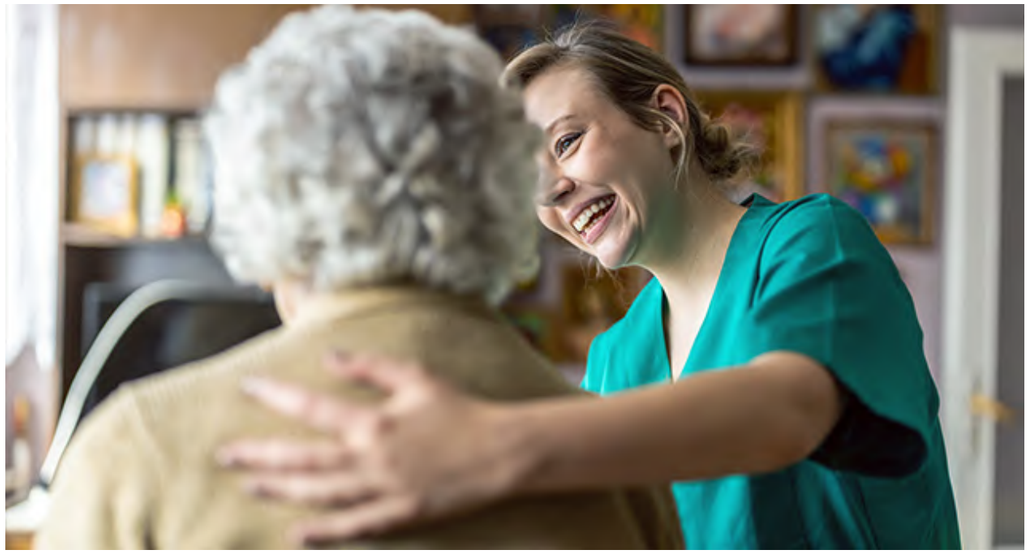
The project abandoned the classical "purchasing"-oriented approach and developed a collaboration-based model. Previously, a system in which the public sector was predominantly the direct provider created an unsustainable structure by excluding private and voluntary organizations. In the new approach, all actors have been included in the process, a "fair price" understanding has been adopted, and unstable practices that undermined the credibility of independent providers have been ended. In addition, resources have been prioritized using the Programme Budgeting and Marginal Analysis (PBMA) method, thereby ensuring both cost control and service quality.

One of the outstanding innovations is the development of a joint recruitment strategy for care workers and the introduction of the "living wage" from 2014 onward. This practice reduced staff turnover in the sector and improved service quality. Another notable development has been the provision of services previously considered impossible in rural areas through "community-based pop-up care" models. This approach has enabled local communities to build care capacity in collaboration with independent providers, making access to care-at-home services possible even in the most remote areas.

The financing model has also played an important role in the success of the implementation. At the first stage, approximately £0.5 million was used to cover costs that arose during the system's transition period. Other resources were provided by redirecting existing management capacities, enabling the project to be implemented without additional burden on the national budget. In the long term, sustainability has been ensured by replacing high-cost institutional-care services with lower-cost, quality care-at-home services.

The results clearly demonstrate the model's impact. More people have been able to maintain independent living at home, delays experienced by individuals discharged from hospital while waiting for care-at-home have been largely reduced and, in some areas, completely eliminated. This has saved hospital bed-days and eased pressure on the health system. In addition, service quality has improved and opportunities for care at home have expanded even in rural areas. One of the most important gains has been the creation of a trust-based culture of cooperation between public institutions and providers. Relationships previously characterized by conflict and mistrust have transformed into a structure that develops joint solutions and intervenes in problems together.

The project has not remained limited to the Highland region, it has started to spread to northern and western regions of Scotland. With its cost effectiveness and social benefits, this implementation provides sustainable solutions for the increasing care needs of an ageing population. The model, which creates high impact in the medium term, is expected to become a standard practice at national level in the long term.



SOURCE: European Commission. Equitable access to health services. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/113

A PSYCHO-EDUCATION AND RESILIENCE MODEL FOR REFUGEES

LOCATION: Netherlands

DATE: 2008 - ongoing

Resilience | Psycho-education | Refugee Health | Cultural Adaptability

PROJECT TITLE — ARQ (NGO)-Mind-Spring programme

TARGET GROUP — Refugees, asylum seekers, migrant communities

PREVENTION LEVELS — Primary Prevention

Compared to the local population, refugees are at much higher risk in terms of mental health due to war, forced migration, and cultural-adaptation problems. In host countries, their access to health services is often limited, because of stigma, language barriers, and lack of trust, they hesitate to seek support. This leads to worsening of problems such as depression, anxiety, and post-traumatic stress disorder, adversely affecting both individual well-being and social cohesion. Developed in response to this picture, the Mind-Spring Programme is an innovative initiative implemented to strengthen refugees' mental health, increase their psycho-social skills, and develop their resilience.

The most striking aspect of the programme is the dual-trainer model. The training is conducted by two trainers, one with a refugee background and the other a Dutch mental health professional.

Because a refugee trainer knows the participants' cultural codes, values, and communication styles well, they create an environment of trust, while the professional trainer can provide advanced referrals when necessary. This structure enables not only knowledge transfer but also a culturally sensitive and safe learning environment.

Mind-Spring's core aim is to reduce refugees' need for specialized mental health services and prevent problems from worsening through early-support mechanisms. Through psycho-education, individuals develop healthier coping methods for traumas and adaptation problems, integrate more quickly into society, and have increased chances of participating in the workforce. The programme also helps refugees build social relationships, participate in volunteer activities, and rebuild self-confidence.

Implementation steps include designing sessions together with refugee communities, establishing coordination with local mental health institutions, and developing a "training-of-trainers" model. In this way, the programme can be adapted to local conditions in different countries and disseminated sustainably. Participants' progress is monitored with four different surveys (WHO-5, BRS-6, Cantril's Ladder, SOC-K), changes in mental well-being, resilience levels, and depressive symptoms are measured with concrete data.

The most innovative aspect of the programme is that it does not see refugees merely as "recipients of help" but as active subjects of the training process. Having a refugee as one of the trainers facilitates participants' self expression and reduces fear of stigma. Unlike classical counselling approaches, this model creates a learning environment based on trust and shared experience. In addition, the programme not only protects mental health but also supports refugees' participation in social life, employment opportunities, and their connection with society through volunteering.

Financing is largely provided by local municipalities and international mental health institutions. The costs of trainings are often covered by municipal budgets, while the international training-of-trainers programme is supported by institutions wishing to work with refugees. This financing model makes both sustainability and dissemination in different countries possible.

Among refugees who participated in Mind-Spring, depressive symptoms decreased, psychological resilience increased, and life satisfaction rose. Participants' departure from social isolation, participation in the workforce, and orientation toward volunteering contributed to social integration. Qualitative research shows that refugees define themselves after the programme as stronger, more self-confident individuals who look to the future with more hope.

SOURCE: European Commission. Community health support for vulnerable groups. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/445

MOBILE HEALTH SERVICES FOR RURAL AREAS

LOCATION: South Karelia Region, Finland

DATE: 2011 - ongoing

Mobile Clinic | Preventive Health | Social Inclusion | Rural Health Services

PLACE | PEOPLE | PARTICIPATION | 3 GOOD HEALTH AND WELL-BEING | 10 REDUCED INEQUALITIES

PROJECT TITLE
Mallu does the Rounds

TARGET GROUP
Older people living in rural areas, individuals with chronic conditions, low income populations

PREVENTION LEVELS
Primary Prevention

The Mallu Does the Rounds project is an innovative mobile service developed to address the major difficulties in access to health and social services among geographically isolated individuals living in rural areas of Finland. In Finland's rural areas, where the older population is rapidly increasing, access to health centres has become difficult due to both distance and cost. This mobile clinic implementation, launched in 2011, aims not only to meet individuals' basic health needs but also to reduce rural poverty and social exclusion.

The project is built around a converted mobile caravan visiting villages on fixed routes at regular intervals. During these visits, held every two weeks, nurses perform blood pressure and blood sugar measurements, minor procedures such as suture removal and ear irrigation, and provide vaccination and injection services.

In addition, thematic days such as diabetes awareness are organized, thereby supporting preventive health services. The mobile unit is equipped with a computer and broadband connections, enabling access to patient record systems, remote connections with specialist physicians, and transfer of data to the central system. Thus, in addition to treatment, data are collected to identify health needs in rural areas.

The Mallu project is run by the South Karelia Social and Health Care District (Eksote) and covers nine municipalities. Initially starting with influenza vaccination services, the implementation was expanded over time with additional services such as oral health, physiotherapy, psychological support, and substance abuse counselling. Collaboration with local village associations, support of volunteers, and strong coordination mechanisms have played key roles in the project's success.

In terms of financing, the project received €48,000 from the European Agricultural Fund for Rural Development (EAFRD) and was carried out with a total budget of €112,000. Additional resources were provided through the Finland Rural Development Programme. This low cost model has served a broad rural population, improving health outcomes and demonstrating cost effectiveness. In the first two years of the pilot implementation, services were delivered to more than 100,000 potential patients, and significant improvements were achieved in older people's quality of life and access to health services.

An evaluation conducted in 2013 showed that the project supports independent living especially for older adults, reduces unnecessary hospital visits, and increases efficiency in the health system. In addition, the Mallu model has a structure that can be supported by tele-medicine applications. This carries the potential to expand the project's scope in the future with services such as remote patient monitoring and video consultations.

SOURCE: European Commission. Health promotion in disadvantaged areas. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/93

ACCESS TO HEALTHY FOOD AND EMPLOYMENT THROUGH SOLIDARITY GROCERIES

LOCATION: France (national level, also adapted in Belgium, Luxembourg, Austria, Romania, and Greece)

DATE: 2008 - ongoing

Solidarity Groceries | Employment Integration | Social Inclusion | Access to Healthy Food

PROJECT TITLE
Action nutritionelle dans une épicerie solidaire

TARGET GROUP
Low income households, unemployed individuals, groups in need of social inclusion support

PREVENTION LEVELS
Primary Prevention

The "Action nutritionnelle dans une épicerie solidaire" ["Healthy Eating and Social Integration through Solidarity Groceries" Programme] is an innovative social enterprise established in 2008 in France. The enterprise aims to facilitate access to healthy food for people at risk of poverty and to provide re-employment opportunities for those who have been unemployed for a long time. The programme's main objective is to facilitate access to fresh fruit and vegetables at affordable prices for low income groups and to support their reintegration into the labour market by offering work experience in these groceries. Products in solidarity groceries are offered at 10-20% of market prices, making healthy food accessible for low income households. This approach presents a multi-dimensional solution model that brings together food security and social inclusion policies.

The programme is run by A.N.D.E.S. (Association Nationale de Développement des Épiceries Solidaires), which operates on a national scale. A.N.D.E.S. provides critical support such as developing business plans for the establishment and operation of groceries, conducting market analyses, providing training for managers and volunteers, and organizing the supply chain. In addition, partnerships with the food industry, supermarkets, and local farmers ensure the flow of quality products. Through four large collection centres, the organization gathers fresh fruit and vegetables from wholesale markets and distributes them to the groceries, in this process, 85 long term unemployed individuals employed at the centres have obtained a 67% rate of re-employment or renewed motivation for work thanks to the programme. Today there are more than 500 solidarity groceries across France, and approximately 120,000-170,000 people benefit from these groceries each year.

On average, each grocery serves 100 households per year. Independent evaluations show a marked increase in the consumption of fresh fruit and vegetables among those shopping at these groceries. For example, 43% of customers report consuming at least two portions of fruit per day, whereas this rate is only 23% in the control group. Vegetable consumption reaches 52%, while it remains at 30% in the control group. These data demonstrate that the programme strengthens healthy eating habits.

Three key factors underpin the programme's success. First is the broad partnership network developed by A.N.D.E.S. between public institutions (the Ministry of Labour and Social Dialogue, the Ministry of Agriculture and Fisheries, local authorities) and private sector companies (such as Ferrero, L'Oréal, PepsiCo, and Monoprix). These partnerships have not only provided financing but also ensured continuity of the programme through food donations and logistical support. Second, in the design of the groceries, to prevent stigmatization, a "normal" supermarket like appearance has been preferred so customers can shop freely and with dignity. The third factor is that reintegrating long term unemployed individuals into the workforce has been placed at the centre of the programme. In this way, access to healthy food and employment policies are combined within a holistic framework.

One of the biggest challenges the programme faces is ensuring the sustainable supply of high quality food products. This problem has been overcome by establishing long term collaborations with the food industry and wholesale markets.

In addition, users' low income levels, lack of storage facilities, and insufficient knowledge regarding the preparation of healthy food have been factors that limit consumption habits. For this reason, A.N.D.E.S. has focused on reducing these barriers by organizing nutrition awareness and food preparation workshops.

Innovative aspects of the programme include combining access to healthy food with social inclusion and employment dimensions, and transforming solidarity groceries into spaces of social interaction beyond being merely places of shopping. In addition, the establishment of similar groceries in countries such as Belgium, Luxembourg, Austria, Romania, and Greece proves the transferability of this model.

SOURCE: European Commission. Reducing health inequalities. https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/94

COMMUNITY-BASED CARE PROGRAMME

LOCATION: Gwangju, Republic of Korea

DATE: 2021 - ongoing

Community-based Care | Digital Social Services | Vulnerable Groups | Care Integration

PROJECT TITLE

TARGET GROUP

PREVENTION LEVELS

GwanJuness Community Care

Older adults, persons with disabilities, individuals living alone, children, low income households

Primary Prevention

The 2021 Social Security Survey conducted in Gwangju, the sixth largest city in the Republic of Korea, revealed that citizens see care services as the most urgent problem. Vulnerable groups such as older adults, persons with disabilities, and children face serious barriers to accessing information and application procedures in the existing welfare system. The need for individuals to apply separately to many institutions to meet different needs leads to a time consuming and exhausting process, causing the most vulnerable segments to be deprived of support. In this context, the city of Gwangju has developed a community-based care system based on digitalization, holistic planning, and inter-institutional cooperation to ensure that no one is deprived of care services. The core objective of the project has been to establish a comprehensive care infrastructure in the city by providing social assistance and health supports in an accessible, fast, and reliable manner.

This initiative has been designed not as a single pilot implementation, but as a multi-stakeholder, community-based care model that has evolved into a structure that could set an example at national scale.

At the centre of the implementation lies a single line digital application channel called “Care Call.” Every application that citizens make to the Gu office is immediately transmitted to the Dong-office care managers, who then conduct home visits and record care needs into the system via tablets. These data are instantly transferred to the central web system, an appropriate service is selected, and referral is made to the relevant private organization. Staff of the organization record service details via their smartphones and provide real time feedback to the managers. Thus, the process has become trackable in real time from application to completion of service.

The services provided under the project cover a wide range. Individuals living alone, those at risk of suicide, persons with disabilities, and those with chronic conditions receive special support. According to 2023 data, home nutrition support was provided to 3,067 people, assistance with household chores and cleaning to 1,108 people, home health visits and rehabilitation services to 917 people, and vital services such as cleaning, pest control, disease prevention, and home repair to 2,022 people. In this way, living conditions in the city have become healthier and safer. One of the most striking outcomes of the programme is that 97.8% of the beneficiaries are low income individuals. Thus, an important step has been taken towards reducing social inequalities. In addition, 700 new care staff have been employed, contributing to the local economy.

The project feeds both service delivery and policy making. Demographic, socioeconomic, and health data collected by Dong offices are analysed by the Gwangju Social Service Institute and presented to the municipal administration. In this way, a scientifically grounded evaluation mechanism has been established for future planning. Administratively, problems experienced regarding budget sharing between the city and the Gu offices have been resolved through determined negotiations, and a total of $7.74 million has been allocated for 2023 at a 75% city - 25% Gu-office split. In addition, 78 training sessions have been held to increase the competence of 1,000 care managers, strengthening the programme’s quality.

One of the innovative aspects is the integration into the system of traditional medical practices widely trusted in Korean society. Seventy four traditional medicine physicians have been included in the programme for management of chronic pain and ailments. In addition, active participation of the private sector has been ensured by defining 16 new care services, and selected institutions have been included in the process through quality assessments.

This approach has ensured that the system is both innovative and responsive to social expectations.

When the results are examined, it is seen that the programme not only improves individuals’ quality of life but also contributes to the prevention of suicides and lonely deaths. Citizens have become able to access five different services with a single application, and public awareness has increased regarding the national importance of care services. Other cities such as Busan, Jeju, Daejeon, and Suwon have examined the Gwangju model and have begun considering its implementation in their own regions. In addition, academic institutions and research institutes have brought the programme forward as a case study in the field of social policy.

Overall, the Gwangju Community Based Care Programme has presented an inclusive social care model by combining technology, public/private cooperation, and community participation. In the future, it is expected that this model will be disseminated to other cities in the Republic of Korea and to countries facing similar demographic challenges.

SOURCE: Metropolis. Gwanjuness community care.
https://use.metropolis.org/case-studies/gwanjuness-community-care

MANAGING ACTIVE AND HEALTHY AGEING WITH USE OF CARING SERVICE ROBOTS

LOCATION: Puglia, Italy (Europe-wide: Ireland, France, Greece, Germany, United Kingdom)
DATE: 2016 - ongoing

Comprehensive Geriatric Assessment | Caring Service Robots | Dementia | Combating Loneliness

PLACE | PEOPLE | PARTICIPATION

3 GOOD HEALTH AND WELL-BEING | 9 SANAYİ, YENİLİKÇİLİK VE ALTYAPI | 10 REDUCED INEQUALITIES

PROJECT TITLE
MARIO - Managing active and healthy ageing with use of caring service robots

TARGET GROUP
People with dementia, older adults, carers, health professionals

PREVENTION LEVELS
Tertiary Prevention

The MARIO project was launched to develop an innovative solution to the multi-faceted problems caused by loneliness, isolation, and dementia among older adults. The project is financed by the European Union under H2020, with pilot implementations in Italy, Ireland, France, Greece, Germany, and the United Kingdom. In the Puglia region it is being tested in geriatric clinics in San Giovanni Rotondo.

The project develops robots that support the processes of Comprehensive Geriatric Assessment (CGA), especially for patients in the early stages of dementia. These robots can measure patients' activities of daily living (such as eating, dressing, and medication tracking) and cognitive functions using natural language processing and sensors. In this way, clinicians' workload is reduced and more accurate and comprehensive data can be collected.

The most innovative aspect of MARIO is that it not only performs medical measurements but also strengthens social connections. Robots mediate communication between older adults and their families, provide access to areas of interest, and help keep social ties alive. In this way, the adverse effects of loneliness and isolation on health are alleviated.

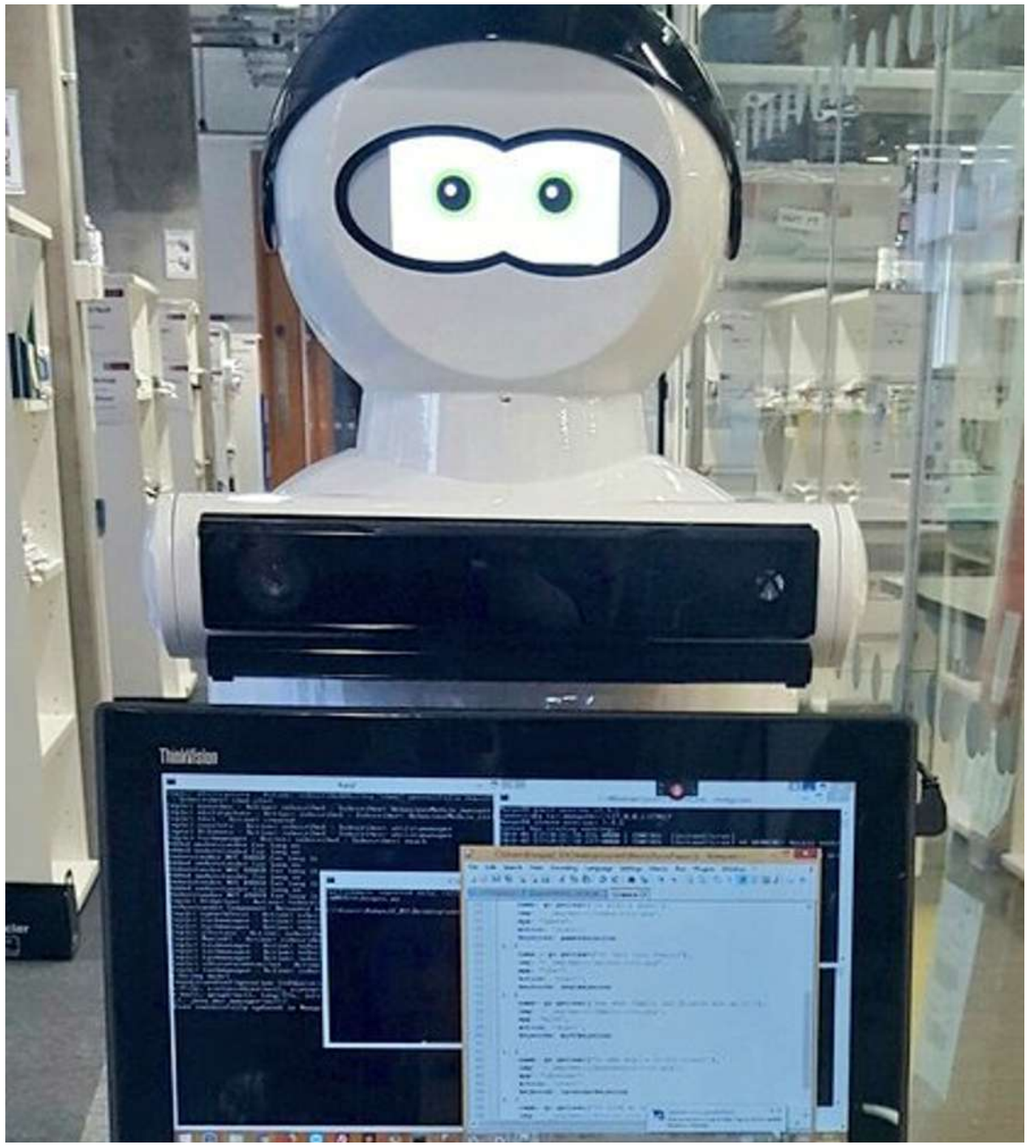
Patients, carers, and health workers have been directly involved in the development of the project. As a result of interviews with 88 people with dementia and more than 200 carers, a user friendly, acceptable, and sustainable model has been created. Integration of robots into clinical practice produces outcomes that are cost equivalent and superior in health results.

MARIO's total budget is in the range of €1-5 million, with the main source being European Commission funds.

Initial trials began in 2016 and positive feedback was received in a short time. Although the cost of one robot is high, the cost per patient can be reduced to below €1,000. This shows that it offers a cost effective solution in the long term.

In the short term, the objective is to improve the quality of life of people with dementia, slow cognitive decline, and reduce health workers' workload.

In the long term, wider scale diffusion of MARIO will ensure that digital solutions become part of routine practice in elder care. Although transfer potential across Europe is considered high, the project is currently proceeding at a project specific pilot scale.



SOURCES: European Commission. (2017). Managing active and healthy ageing with use of caring service robots.
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