2016

Responding To Needs, Driving Change

CDI Healthy Schools' Programme
Policy Paper
Healthy Schools - Healthy Children

1.0 Introduction

This Policy Brief[1] outlines the learning from the independently evaluated 'Healthy Schools Programme' (HSP) which was designed and delivered by the Childhood Development Initiative (CDI), between 2008 and 2012. The aim of the HSP was to improve children's health and well being and increase access to primary care services. CDI supports the delivery of a range of early intervention and prevention programmes to improve outcomes for children in disadvantaged areas. CDI became one of three Dublin based Prevention and Early Intervention Programmes (PEIP) in 2007. In June 2013 it was included in the Government's Area Based Childhood (ABC) Programme.

The Brief draws on the original evaluation carried out in 2011 (Comiskey et al, 2012) and a subsequent follow-up study completed in 2013 (Comiskey et al, 2013), as well as consultation with key stakeholders. The learning is placed in the context of relevant public policy developments and briefly reviews the practice context in terms of what can assist or act as barriers to successful implementation. The focus in this Policy Brief is on Primary Schools as this is the context of the HSP intervention and learning. However, it also has relevance for early childhood care and education, Post Primary Schools and other learning contexts used by young people.

The production of this Brief was prompted by the identification in the follow-up study of significantly improved outcomes for the children involved. It is hoped that these will inspire policy makers and implementers to further develop and support the role of schools in promoting the health and well being of children.

[1] This policy brief draws on an original policy brief entitled 'Developing a Health Promoting School through the Healthy Schools Programme' (2012).

1.1 Health Promoting School (HPS)

A HPS[2] is one in which all members of the school community work together to provide pupils with integrated, positive experiences and structures which promote and protect their health (WHO, 1997). One of the most significant features of effective health promoting schools as highlighted in the literature is the adoption of a whole school approach:
"There is a need for a strategic and whole-school approach to planning to be undertaken at the school level; one that is informed by self-evaluation and that is inclusive of the views of the entire school community i.e. staff, parents, children, and services that are part of the schools' functioning" (Weare & Markham, 2005, Pg. 118-122).

The HSE-HPS Framework for 'Developing a Health Promoting School' (2013) also emphasises the importance of a whole school approach, stating that this implies:

- Systemic processes for planning and reviewing policies;
- An inclusive and involved school community;
- A team work approach to the HPS process.

The CDI evaluation encapsulates the scope of the system wide approach, citing Lahiff (2008) as follows:
"This includes both the formal and informal health curriculum, the creation of a safe and healthy school environment, the provision of appropriate health services and the involvement of the family and wider community in efforts to promote health" (Comiskey et al, 2012, Pg. 1).

1.2 Rationale for HPS

There is considerable concern in policy circles regarding children and young people's health and wellbeing as evidenced in current policy debates and developments. These concerns relate particularly to childhood obesity, emotional wellbeing, positive mental health, inadequate levels of physical activity, and levels of smoking, alcohol and substance misuse. Recent policy developments emphasise both the rights of children to positive health and wellbeing as well as the significant costs to the State due to ill health later in life.

It is increasingly recognised that schools play a central role in promoting the health and well being of children. The Department of Education advocates that all schools in Ireland include a health promotion approach in both the curriculum and in their duty of care for children's health (Department of Education, 2007). In addition to health and wellbeing outcomes a HPS approach has been linked to improved academic performance (HSE, 2013; DES, 2015). The importance of this approach is particularly emphasised in literature dealing with educational disadvantage and children affected by poverty and social exclusion (CDI, 2012).

1.3 Background to CDI's Healthy Schools Programme (HSP)

CDI's HSP was developed following extensive collaboration with those living and working in the community[3]. It drew on international evidence of what works in addressing children's health and well being. The Programme was delivered in five DEIS Band One Primary Schools in Tallaght West and was accompanied by a robust evaluation process in order to secure an evidence base for the Intervention.

The broad aims of the HSP were improvements in:

- Children's physical and psychological well-being;
- Access to and uptake of health care services and effective referral systems;
- Involvement of parents and families in their children's health.

The Programme was supported at school level by HSP Coordinators and guided by an Interagency Steering Committee.

1.4 Findings from the HSP Evaluation and Follow-up Study

A detailed evaluation of CDI's model was carried out employing a quasi experimental approach. This meant that two schools not receiving the intervention were included in the study, for comparative purposes. A follow up study was conducted in 2012 and published in 2013; both studies were conducted by Trinity College Dublin. The original evaluation measured outcomes and included a process evaluation which examined implementation aspects.

Whilst the original evaluation (2012) did not identify significant findings in terms of outcomes, it did identify issues relating to the health profile of children in DEIS schools which should be of national concern. The report states:

[2] The HSE has a Programme called Health Promoting Schools; HSE–HPS will be used when referring to this Programme. The CDI intervention was called the Healthy Schools Programme (HSP).
[3] The HSE-HPS Programme was in existence at the time of development of the CDI intervention but did not have a nationally agreed framework or an evaluation of outcomes and impact in the Irish context. The CDI Policy Paper (2012) published following the original evaluation of the CDI-HSP called for a national framework. This was published by the HSE in 2103.

"…there are sizeable proportions of children with below average Health Related Quality of Life on specific domains and a proportion of children with above-average depressive symptoms" (Comiskey et al, 2012:9).

The evaluation also captured significant learning in relation to implementation of the Programme at school level. The key findings stressed the following needs:

- A strategic and whole school approach to planning, informed by School Self Evaluation (SSE) and views of the whole school community including staff, parents, children and services linked to the school;
- Allowing schools a long lead in time and development phase prior to independent evaluation beginning so that the programme can bed down;
- Investment in pre-implementation planning and supporting schools to be 'HSP ready';
- HSP Coordinator (and implementation team) should be adequately trained in HPS theory and practices and work closely with HSE Health Promotion Services:
- Principals as drivers of the HSP and leaders of change;
- Role of HSP Coordinators in supporting policy development, teacher capacity building and interagency collaboration;
- Provision of clear steps for schools to follow and tools to assist decision-making;
- Long-term support from both the DES and the HSE to ensure development of health promoting school environments has support in the long term;
- Collaboration from local health services;
- Parental engagement as a key factor in developing and implementing a health promoting school.

Importantly the evaluation report (2012) concluded that outcomes for children arising from a healthy school approach need to be monitored in the medium to longer term rather than the short term, prompting Comiskey to undertake a follow up study focusing on outcomes for children in the schools included in the original study. It indicated significant outcomes for children in the intervention schools, compared to those in the comparison schools in terms of social support and peer relations; and improved Body Mass Index (BMI), (Comiskey, et al 2013).

These findings have particular significance, and highlight the potential contribution of a health promoting school approach, in improving health and wellbeing outcomes.

2.0 Public Policy Context

There have been a number of significant policy developments in recent years relevant to children's health and wellbeing and to the further development and embedding of a health promoting school approach.

2.1 Fit with National Policies

Policy	Focus	Relevance of a Health Promoting School
Better Outcomes, Brighter Futures (DCYA, 2014).	Five core outcome areas: **1.** Active and healthy; **2.** Achieving in all areas; **3.** Safe and protected; **4.** Economic security; **5.** Connected, respected and contributing.	Particularly 1, 2 and 5.
Healthy Ireland (DoH, 2013).	Four key goals: **1.** Increase the proportion of people who are healthy at all stages of life; **2.** Reduce health inequalities; **3.** Protect the public from threats to health and wellbeing; **4.** Create an environment where every individual and sector can play their part in achieving a healthy Ireland.	Particularly 1, 2 and 4.
Connecting for Life (NOSP, 2015).	Seven Goals: **1.** Better understanding of suicidal behaviour; **2.** Supporting communities to prevent and respond to suicidal behaviour; **3.** Targeted approaches for those vulnerable to suicide; **4.** Improved access, consistency and integration of services; **5.** Safe and high quality services; **6.** Reduce access to means; **7.** Better data and research.	Particularly 1, 2, 3 and 4.
National Youth Strategy (DCYA, 2015).	Five Priorities: **1.** Active and healthy, physical and mental well-being; **2.** Achieving full potential in all areas of learning and development; **3.** Safe and protected from harm; **4.** Economic security and opportunity; **5.** Connected, respected and contributing to their world.	Particularly 1 and 2 and potentially 5.
National Strategy on Children and Young People's Participation in Decision-Making (DCYA, 2015).	Four key areas named in which children will have a voice in decision making that affects them: **1.** Local communities; **2.** Formal and non-formal education; **3.** Health and social services; **4.** Courts and legal system.	Particularly 1, 2 and 3.

All of these policies bear relevance in relation to promoting the health and wellbeing of children. The following three national policies are also of particular relevance to the health and well being of children and young people:

- National Physical Activity Plan, (2016);
- National Obesity Policy, (2016);
- National Sexual Health Policy, (2015).

For children affected by poverty and disadvantage, the National Action Plan for Social Inclusion 2007-2016 (DSFA, 2007) and the Delivering Equality of Opportunity in Schools Programme (DEIS, 2006) are of particular relevance. In a DEIS review undertaken in 2016, many commentators highlighted that students in DEIS schools require additional school based supports to promote their health and wellbeing as well as educational outcomes. The HSE-HPS Framework Primary (2013) also highlights that a health promoting school can make a significant contribution to reducing health inequalities.

2.2 Policy Support for a HPS Approach

In addition to the emphasis on the role of schools in the policies outlined above, all policy makers and implementers interviewed for the purpose of this paper emphasised the importance of schools in promoting the health and well being of children. This was particularly supported in relation to children experiencing poverty and disadvantage. It was equally recognised that it is not the sole responsibility of schools to deliver this approach, and that a strong partnership between the Departments of Education and Skills and Health was critical to the successful implementation of a HPS approach.

It was also stressed that other Government Departments have an important role to play including the Department of Children and Youth Affairs (DCYA) and Department of Social Protection (DSP). Tusla, under the auspices of DCYA), is now the dedicated State agency responsible for improving wellbeing and outcomes for children, which includes the National Education Welfare Board, which oversees the Home School Community Liaison Programme (HSCL). In addition DCYA supports and oversees the Children and Young Peoples Services Committees (CYPSCs) which have a crucial role to play in integrating services at local level and thus a potential role in supporting health promoting schools. The DSP funds the School Food Programme which is particularly important to the physical health of children in DEIS schools. A recent report highlights that participation in breakfast clubs can have broader health and wellbeing outcomes including improved relationships with staff and improved behaviour in class (Healthy Food for All - HFfA, 2012).

A health promoting school approach dovetails with current policy developments in relation to an emphasis on:

- Cross departmental, interagency and cross sectoral working in the interests of children and young people;
- Prevention and early intervention;
- Effective engagement with families and communities;
- Participation and voices of children and young people in shaping policy and practice;
- Importance of evidence based models and interventions;
- Monitoring of outcomes and impact.

2.3 Current National Implementation Strategies for HPS

The HSE-HPS is currently the model promoted and supported nationally. This model originated in a European initiative in 1992 and is grounded in the World Health Organisation (WHO) model of health promoting schools. It has evolved and developed since its initial inception. It sets out four key elements to be addressed in developing a HPS: environment; curriculum and learning; policy and planning, and partnerships (HSE, 2013).

The HSE adopted a more national approach in 2012, resulting in the production of Frameworks for Primary and Post Primary Schools in 2013 (reviewed in 2015) to guide implementation at school level. These were accompanied by Coordinators Handbooks. A National Coordinator was appointed in 2013.

Approximately 15%[4] of all schools are recognised as HSE-HPS (September 2015). This is comprised of 482 Primary Schools (14.6%)[5] and 149 Post Primary Schools (20.7%).

Approximately 19% of the primary schools involved are DEIS schools[6], representing 91 schools or 14% of all DEIS primary schools.

In addition approximately 1.5% of primary schools work with HSE Health Promotion Officers to support health promoting activities but are not signed up for full HPS recognition.

The DES and Department of Health (DoH) have had a partnership group since 2000 to deliver on Social Personal and Health Education (SPHE) in post primary schools. Linked to the publication of Healthy Ireland (HI) (2013) and the establishment of the Health and Wellbeing Division in the DoH, a renewed partnership has been established called the Health and Wellbeing Partnership. The purpose of this is to 'build on previous experience and foster greater collaboration and cooperation in the implementation of both Departments' policies on health promotion in the school setting' (HSE 2015-Internal Document).

There is a proposal to involve all schools in the HI agenda by 2020. A HSE Health and Wellbeing Education Advisory Group (HSE, 2015) is currently being established to lead the development of a plan to achieve this. The plan will clarify the nature of the participation and how this will be rolled out and supported.

The consultation for this paper established that it is not envisaged at this point that all schools will adopt a full HSE-HPS approach as part of this roll-out. A number of issues were identified which appear to explain this decision. These include resourcing in terms of the number of Health Promotion Officers available to support schools and also a number of school level issues. These are outlined under the Practice Context below.

2.4 Department of Education and Skills and HPS Approach

The DES plays a key role in promoting children's health and well being at Primary and Post Primary level in a diverse range of ways. These include through:

- Curriculum, for example, SPHE, Physical Education (PE) and Activity (PA);
- Teacher development, for example, the Professional Development Support Team (PDST) and the Health and Wellbeing Support Team;
- Support for Whole School Planning and School Self Evaluation (SSE).

It was advised that the theme of wellbeing is high on the DES's agenda and is becoming a core focus for SSE. It was also advised that additional personnel have been recruited to the PDST to support schools in relation to PE and PA.

In addition, the DES issues guidelines and circulars to schools which advocate particular approaches and policies at school level. Relevant examples in the context of a health promoting school include those relating to SPHE, PE, SSE, anti-bullying and student councils amongst others. DES also produced a framework entitled 'Get Active! Physical Education, Physical Activity and Sport for Children and Young People' (DES, 2012). Associated with this is an Active School Flag funded by DES and supported by DoH and HSE.

One of the most significant developments in terms of a move toward all schools adopting a HPS approach is Circular 0051/2015 and Circular 0013/2016, entitled 'Promotion of Healthy Lifestyles in Post Primary Schools and 'Promotion of Healthy Lifestyles in Primary Schools'. The circulars state: 'Boards of Management and Principals are strongly encouraged to participate in the HPS Initiative'. This refers to the HSE-HPS.

[4] The data outlined here was provided by HSE-HPS personnel. Two DES Circulars 0051/2015 and 0013/2016 refers to 37% of Post Primary and 40% of Primary Schools 'currently participating in, or are in process of becoming involved in' the HPS.
[5] In 2013-2014 there were approximately 3300 primary and 720 post primary schools http://www.education.ie/en/Publications/Statistics/Key-Statistics/Key-Statistics-2013-2014.pdf
[6] In 2015-2016 there were 646 DEIS Primary schools http://www.education.ie/en/Schools-Colleges/Services/DEIS-Delivering-Equality-of-Opportunity-in-Schools-/

Because of the nature and structure of the Irish education system, the DES is not empowered to direct schools to take specific actions such as implement a HPS approach. They can encourage as evidenced in the recent Circulars. This structural issue poses a challenge to the full adoption of a systemic, embedded health promoting school approach in all schools. However the DES does support schools through a range of mechanisms including the following:

- The DEIS Programme supports health and wellbeing outcomes for children effected by poverty and disadvantage. Improved educational outcomes are the priority but offering a range of school based supports has the potential to contribute to wider outcomes;
- The National Education Psychological Service (NEPS), which is concerned with learning, behaviour and social and emotional development;
- The publication of the Mental Health and Wellbeing Guidelines for Primary and Post Primary Schools (2015). The development of the Guidelines involved DES, NEPS, DoH and HSE and they endorse the HSE-HPS approach as well as the NEPS continuum of support[7]. https://www.education.ie/en/Publications/Education-Reports/Well-Being-in-Primary-Schools-Guidelines-for-Mental-Health-Promotion.pdf

2.5 Coherence between Strategies and Implementation Initiatives

The above policies and strategies are welcomed as they increase the emphasis on children's health and well being, and demonstrate a commitment to children experiencing poverty and disadvantage. They emphasise the role of schools (with others) in promoting and supporting children's health and well being. These commitments can be strengthened by ensuring integration and coherence between policies as well as plans, frameworks and guidelines. The National Youth Strategy's first priority focuses on children and young people being 'active and healthy, physical and mental well-being'. In this context it calls for the full implementation of the Active School Framework and SPHE in a whole school manner. It does not mention the HSE-HPS model. The DES Circular referred to earlier pulls together previous guidelines and circulars including PE, the Active School Framework, healthy eating policies and the promotion of the HSE-HPS. It does not mention the Mental Health and Wellbeing Guidelines. DES advised that it is currently considering the guidance to give to schools on the implementation of the Guidelines.

The policies mentioned earlier should advocate for a health promoting school approach.

The recent review of DEIS takes account of the benefits of a HPS approach with vulnerable children. In addition the appointment of a new National Manager of the Education Welfare Service (with responsibility for the HSCL service) offers opportunities for greater liaison between this service and future developments in the HSE-HPS approach.

Overall robust implementation and oversight of all the policies mentioned above is needed to ensure the best outcomes for children's health and well being. Johnston, (2012) argues that in order to ensure successful implementation of national policies three interlinked approaches are needed: top down; bottom up and a transformative approach. While a bottom up approach is necessary but not sufficient alone, she stresses the importance of:

- Authoritative, accountable leadership (top down); and
- Identifying and addressing the resistors (transformative).

2.6 Wider Economic Policy Context

The research for this paper identified barriers in the broader public policy environment to a fuller rollout of a HPS approach. These include reductions in levels of resources and staffing both in schools and in the HSE Health Promotion area, as well as in wider health and public services. These areas are central to the implementation of the approach. The loss of school posts of responsibility were particularly emphasised as mitigating against implementation of school wide initiatives:
"Without well resourced health and education services, the function of a health-promoting schools programme in supporting better inter-agency working between schools and other services is compromised" (Comiskey, et al, 2012:86).

[7] This refers to a three tier approach to support: for all; for some and for a few. These tiers are linked to levels of need - general, mild and complex.

3.0 Practice Context

The structural issues already highlighted including lack of a national policy on HPS; insufficient coherence between relevant National Strategies; level of autonomy of individual schools and economic cutbacks, all impact directly on the practice context. So even where good will exists at school level towards a HPS approach there are factors which mitigate against the adoption of models such as the CDI-HSP or HSE-HPS. The research for this paper identified the following barriers:

3.1 External Barriers

- Lack of posts of responsibility resulting in loss of leadership at school level;
- Reduction in resources to some schools which are struggling to pay bills;
- Families of children in DEIS schools particularly affected by recession, resulting in more demands on schools to provide supports;
- Increasing demands on schools leaving them feeling daunted;
- Insufficient level of services to refer children and families to, for example, Child and Adolescent Mental Health Service (CAMHS) and speech and language therapy;
- Lack of coordination between service providers;
- The number of initiatives targeting schools and lack of coordination between them;
- Insufficient supports available to enable all schools to implement a HPS approach.

3.2 School level barriers:

- Commitment to whole school approaches is not universal;
- Tendency to be reactive rather than reflective in adopting activities and programmes;
- Concerns regarding being held accountable for children's health and wellbeing outcomes which are beyond the control of the school;
- Openness to reflect on school culture and ethos;
- Commitment and capacity to lead and implement school level change;
- Understanding and capacity of teachers to participate in a health promoting school approach.

3.3 What is required to support the development of a health promoting school?

The findings from the HSP Evaluation (2012) outlined at 1.4 above include many of the key factors which support the implementation of a health promoting school approach. The authors highlight that these could inform the implementation of health-promoting school programmes more generally, and outline intervention activities that are more likely to support change in the structural conditions of the school and support whole-school level change. In addition, the following were also emphasised:

- Ensuring a HPS Coordinator is appointed to guide and support the process; both the CDI and HSE models strongly emphasise this aspect. Without this role it is unlikely that a HPS can be achieved.
- Developing strong links and engagement between the Healthy School Coordinator and HSCL Coordinator (in DEIS schools); as well as with SPHE Coordinators and others such as PE or Sports Coordinators (where available). The HSE-HPS model proposes that a Health Promoting School Team be established to plan and develop the initiative.
- Overcoming concerns that the proposed models are daunting or that adopting a HPS approach involves a lot of extra work: it was suggested that initial support could focus on assisting schools to name what they are already doing in terms of promoting the health and wellbeing of children and demonstrating that they may already be fulfilling many aspects.
- Demonstrating how a healthy school approach assists schools in delivering on core elements of the curriculum and its potential contribution to whole school development.
- Securing full buy in from the Principal as evidenced by commitment to drive and lead the process.
- Demonstrating that the model is flexible and can be adapted

to meet the needs of each school.

- Providing a menu of available resources and programmes to assist implementation of the plan.
- Ensuring materials provided to schools are user friendly, accessible and jargon free.

The detailed learning from the CDI process evaluation as well as the school consultation currently being carried out by the DES-DoH Partnership can help inform development of practice.

In considering the extension of participation in a HPS approach, it is important that a strong emphasis is retained on a whole school approach. This will ensure linking the approach to the overall culture and ethos of the school, its policies and procedures, teaching and learning as well as external partnerships with relevant services, as advocated in the CDI and HSE models.

4.0 Recommendations

Barriers in the wider policy context such as reduced resources to schools, health and wellbeing services, need to be addressed in order to create the environment in which a HPS approach can flourish. In addition we recommend the following:

Medium to Long Term Recommendations

1.

Develop a national policy on HPS. 62% of countries who responded to the Schools for Health in Europe (SHE) Network[8] survey have such a policy. The serious health and wellbeing issues affecting children in Ireland including childhood obesity, mental health issues, inadequate physical activity, use of tobacco, alcohol and drugs justify such a development. The development of the National Strategy to Improve Literacy and Numeracy among Children and Young People (2011) acts as a precedent in this regard. The current concerns call for a similar national response. Whilst these issues are cross government and cross society and are already a focus of a number of recent significant policies, the role of HPS is acknowledged nationally and internationally as a key way to address them. In the absence of a specific national policy on HPS, implementation of this approach will continue to depend on the good will of individual schools, particularly given their level of autonomy. Such a policy would also reflect the growing recognition being given to a HPS approach at national policy level. The development of a national policy should be informed by evaluation of the current HSE-HPS, the learning from the CDI studies (2012 and 2013) particularly regarding implementation, and by a robust consultation process.

2.

Review teacher initial education and continuous professional development to ensure these adequately prepare teachers to engage in whole-school approaches.

Short to Medium Term Recommendations

3.

Ensure the plan currently being developed by the HSE Health and Wellbeing Education Advisory Group (in conjunction with the DES-DoH Health and Wellbeing Partnership Group) includes a commitment to roll out a full HPS approach to all DEIS Primary Schools as a first step in a fuller national roll-out.

4.

Provide adequate resources to support this rollout including a post of responsibility to allow the appointment of a HPS Coordinator, within participating schools.

5.

Further develop HSE-HPS data collection to ensure information is available on the numbers and types of schools currently participating as well as the nature of the engagement. The DES Life Skills Surveys could assist in this[9].

6.

Commission an independent evaluation of the HSE-HPS Programme and include a strong focus on outcomes for children (especially in DEIS schools).

7.

Take account of the significant learning regarding implementation outlined in the CDI 2012 study in any future rollout of HSE-HPS, particularly in terms of capacity to provide school level supports.

8.

Develop an implementation plan for the Mental Health and Wellbeing Guidelines (2015) and recommend that implementation at school level is embedded in a HPS approach.

9.

Continue to strengthen the capacity of the PDST in relation to health and wellbeing.

10.

Continue to promote and support a focus on the theme of health and wellbeing in SSE and link this to schools adopting a HPS approach.

11.

Consider amalgamating the current three school flags, (Active School Flag, HSE-HPS Flag and Healthy Ireland School Flag) into one 'Healthy School Flag'.

[8] Ireland is a member of this Network.
[9] The Life Skills Survey is administered by DES periodically. The 2015 survey is currently being processed and the previous survey was in 2012. It is sent to both primary and post primary schools. https://www.education.ie/en/Press-Events/Events/Lifeskills-Survey-2015/Lifeskills-Survey-2015.html

12.
Consider the full implementation of a HPS approach in all DEIS schools in the context of the current review of DEIS. In this regard, engage in discussions with Tusla Education Welfare Services Management to strengthen cooperation at national and local level between the HSCL and HSE-HPS Programme.

13.
Ensure coherence between current national policies and strategies on Physical Activity, Obesity and Sexual Health in terms of the role of schools in their implementation, and commitment to and a promotion of HPS approach.

14.
Consider the role of the Children and Young People's Services Committees (CYPSCs) in supporting a HPS approach especially in relation to the objective of strengthening access to services for children and families. Following this, produce guidelines for CYPSCs.

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Responding To Needs, Driving Change

The Area Based Childhood Programme 2013–2017

An Roinn Leanaí agus Gnóthaí Óige
Department of Children and Youth Affairs

The Atlantic Philanthropies

CES Centre for Effective Services

pobal government supporting communities