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Evaluation of the first implementation phase of the European Strategy for Child and Adolescent Health and Development

Survey 2006–2008

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CONTENTS

Page

Introduction and background 1

The European Strategy for Child and Adolescent Health and Development 1

The evaluation 2

The survey 2

The measurement framework 3

The objectives and indicators 3

Objective 1: Political Commitment 4

Objective 2: The Guiding Principles 5

Objective 3: Child and Adolescent Health Services 6

Objective 4: Information Systems 7

Objective 5: Declarations and Conventions 8

Objective 6: Human Resources 10

The questionnaire 11

Data treatment 12

Data analysis 13

Descriptive data outline 13

Descriptive analysis on each objective 17

Interrelation between different variables 32

Interesting Correlations 35

Conclusion 36

Recommendations 38

Perspectives 38

Appendix 1: The measurement framework 40

Appendix 2: Comments to questions 44

Appendix 3: The Implementation Stages of health promotion programmes 62

Introduction and background

The European Strategy for Child and Adolescent Health and Development

The European Strategy for Child and Adolescent Health and Development presented at the fifty-fifth session of the WHO Regional Committee for Europe, has the goal of supporting Member States in developing strategies and policies to enable children and adolescents to achieve their full potential for health and development and to reduce the burden of avoidable disease and mortality. The strategy is designed to help the Member States achieve the three below objectives:

- Objective 1. **To develop a framework**
  for an evidence-based review and improvement of national child and adolescent health and development policies, programmes and action plans, from a life-course perspective;
- Objective 2. **To promote multisectoral action**
  to address the main health issues related to child and adolescent health;
- Objective 3. **To identify the role of the health sector**
  in the development and coordination of policies and in delivering services that meet the health needs of children and adolescents.

In September 2005 the Regional Committee adopted the European Strategy for Child and Adolescent Health and Development and at the same time it urged the Member States:

- to take steps to develop and implement comprehensive strategies for child and adolescent health in line with the regional strategy, taking into account differences in epidemiological, economic, social, legal and cultural environments and practices;
- to give high priority to making improvements to children's and adolescents' health and development, through advocacy at the highest level, and by scaling up programmes, securing adequate national resources, creating partnerships and ensuring sustained political commitment

In this connection the Regional Director requested:

- to ensure adequate and appropriate support, including the mobilization of resources, from the WHO Regional Office for Europe to Member States in their efforts to develop and implement national policies and strategies for child and adolescent health and development;
- to report to the Regional Committee at its fifty-eighth session on the progress and achievements made in developing and implementing child and adolescent health strategies in the European Region.

In order to secure that the commitment in regard to the adoption of the European Strategy is respected and met, the CAH, WHO Regional Office for Europe has initiated an in depth evaluation of the implementation process and intermediate outcomes of the European Strategy for Child and Adolescent Health and Development. The evaluation is formative and the findings are being disseminated during the research in order to inform policy development as the strategy is being implemented.

There are three essential phases in the implementation process of the European Strategy: Situation analysis; development of a national strategy and action plan; and integrating strategy and action plan in health sector development plans and macroeconomic policies. Added to this there is a parallel, enabling component in building ownership and ensuring coordination among all partners. At this point in the process detailed reports on the situation analysis in 11 out of 12 BCA countries (Albania, Armenia, Georgia, Hungary, Kyrgyzstan, the Republic of Moldova, Slovakia, Tajikistan, Turkey, Ukraine and Uzbekistan) have been developed and national workshops for introducing the European Strategy on Health and Development of Children and Adolescents have been carried out in these countries. The latest national activity plans were developed in May 2007 at a workshop in Florence. These action plans include planned activities; involved stakeholders in the activities; needed support from WHO and/or national institutions for the activities and timeframe. According to the action plans, national strategies will be drafted in most BCA countries during autumn 2007, indicating that national strategies based on the European Strategy are in the pipeline in these Member States.

The evaluation

The aim of the evaluation is to make the national differences visible and understandable. This will happen through a thorough mapping of the current situation in each of the Member States in regard to progress and achievements, barriers and challenges in the implementation process.

The evaluation is carried out in two separate parts in order to cover both the need for general, simple information that can be compared since the data is generalizable and the need for extensive descriptions and analysis of the implementation process taken as a whole and in its context. The first part of the evaluation is a survey based on a questionnaire and the second part consists in several detailed case studies carried out in a number of selected Member States. This report sums up the results, the analysis and the conclusions based on the baseline survey carried out in autumn 2006 and the follow up survey carried out in spring 2008.

The survey

The motivation for doing a survey as a part of the evaluation was first of all the fact that comparable information is necessary to find out what impact the work with the strategy is having on national policies and structures in relation to child and adolescent health in the Member States of the WHO European region. Using a questionnaire is a valuable method of collecting a wide range of information from a large number of respondents and it is therefore considered the adequate method for collecting the needed information from as many of the Member States in the region as possible.

The main purpose of the survey is to collect information on the implementation process of the European Strategy for Child and Adolescent Health and Development. This information should enable the WHO European Office for Europe to report back to Member States as well as to the Regional Committee on the implementation process. The reporting back should include an assessment of the progress and impact of the strategy and an identification of key issues and problems which need to be addressed in more detail if the implementation of the strategy should be improved. Moreover the survey serves as a means to get valuable feedback during the initial implementation phases from many partners and national counterparts affected and involved in the work with the national strategies and the European Strategy for Child and Adolescent Health and Development. It is crucial to view the implementation of the strategy in the light of different

political, financial and cultural contexts. The survey is a step towards a better understanding of how the European strategy fits into the different national circumstances and how it is perceived here.

The survey should purely provide information regarding the *organizational* change. For example it should explain which programmes and activities that have been initiated and which policies and structures that have been changed since the strategy was adopted. Consequently the questionnaire does not ask direct questions regarding e.g. behaviour change, changes in incidence rates or in the different prevalence of the health status measures. The questionnaire is therefore constructed in a way that enables us to answer the following research question:

Which **organizational and political changes** are being carried out in the Member States of the WHO European Region as a result of the **European Strategy for child and adolescent health and development?**

What are the **outputs and early outcomes** from these changes?

The measurement framework

The objectives and indicators

The measurement framework for the implementation of the European Strategy for Child and Adolescent Health and Development represents the link between the objectives and questions in the final questionnaire. The framework was developed through triangulation of the most important sources information: The European Strategy for Child and Adolescent Health and Development; the adjacent assessment tool; the Convention of the Rights of the Child; the 2005 World Summit Outcomes; the CHILD project (Rigby et al. CHILD Report to the European Commission, European Commission, 2002) and a number of discussions with health professionals within child and adolescent health, epidemiologists and public health professionals.

Bringing together these different perspectives on child health led to a variable list containing six main areas that covered the approach:

1. Policies and political development
2. Respecting the four guiding principles of the European Strategy
3. Provision of preventive and curative child health services
4. Standardized collection of data
5. Respecting international conventions and declarations
6. Capacity development

These areas form the core of the entire evaluation and the measurement framework consisting of objectives, indicators and questions has been developed on the basis of these six focus areas.

Objective 1: Political Commitment
Increase political commitment towards development of national strategies

The objective about political commitment in the countries is essential for scale-up, impact and sustainability of effective development and implementation of the strategy. Therefore, sustained political commitment is among the six objectives of the implementation of the strategy.

The commitment of governments to specific policies and programs is notoriously difficult to measure in a quantitative fashion, especially in complex integrated or decentralized health systems. It is still possible to get an impression of whether support is strong, moderate or weak. There are various means by which commitment can be expressed, including 1) Policies, 2) Financing, 3) Multisectoral collaboration, 4) Development and content of policy documents, 5) Upgrading of participation of other agencies and population groups. These areas are covered within the list of indicators described in the following pages.

Indicator 1.1: Initiated development and implementation of a national strategy
Definition: The Government is formally adopting, through legislative and administrative measures, a national strategy of child and adolescent health and development that supports the regionally recommended strategy and tools.

What it measures: Political commitment to action at the central level

Indicator 1.2: Provision of Technical Support from WHO
Definition: The existence of WHO technical support to guide and facilitate the implementation of the strategy.

What it measures: Technical support of WHO consists of reviewing and developing comprehensive child and adolescent health policies and strategies; building capacity for and supporting the implementation of child and adolescent health strategies and integrated intervention packages at national and regional levels; developing and providing standards and guidelines for child and adolescent health policies, strategies, interventions and services; providing technical support in surveillance, monitoring and evaluation; facilitating the development of intersectoral collaboration and structures. See also objective 6.

Indicator 1.3: Existence of a Multisectoral workgroup
Definition: Child and adolescent health taskforce/workgroup with participants from several different sectors. Apart from governmental sectors these workgroups should also be represented by relevant NGOs, the private sector, faith-based groups etc.

What it measures: Existence of a child and adolescent health workgroup which is multisectoral.

Indicator 1.4: Governmental Budgetary Allocations for Child and Adolescent Health and Development
Definition: Budgetary allocations from the Government for projects that concern child and adolescent health defined in a national plan of activities. This can be defined through annual CAH work plans and budgets. To refine the indicator it should state the percentage of the CAH budget, as defined in the annual CAH plan of activities that is funded by the national government.

What it measures: Government's level of financial commitment to child and adolescent health and development.

Indicator 1.5: Participation of NGOs
Definition: Participation of NGOs involved in child and adolescent health and development.

What it measures: Measures whether the partners affected, decision-makers and other persons in NGOs involved in CAH have all been equipped with an opportunity to influence and take part in the development of a national strategy. Participation can be described and measured within different parts of the implementation process. In general it is achieved when groups' and persons' social skills are made use of and influence the national strategy and the following actions.

Objective 2: The Guiding Principles
Ensure the integration of the guiding principles of the European Strategy

The indicators described below this objective have been based on the Strategy document as such. The four guiding principles of the European Strategy for Child and Adolescent Health and Development derive from the commitments already made by the Member States in 2003 and reflect the underlying principles adopted in the WHO document, *Strategic directions for improving the health and development of children and adolescents*. The guiding principles are as follows.

- Life-course approach. Policies and programmes should address the health challenges at each stage of development from prenatal life to adolescence.
- Equity. The needs of the most disadvantaged should be taken into account explicitly when assessing health status and formulating policy and planning services.
- Intersectoral action. An intersectoral, public health approach that addresses the fundamental determinants health should be adopted when devising policies and plans to improve the health of children and adolescents.
- Participation. The public and young people themselves should be involved in the planning, delivery and monitoring of policies and services.

The indicators under this objective measure the link between the above guiding principles and the national strategies for child and adolescent health and development. This is done by evaluating whether the strategy encourages assessment of and attendance to the four areas and relates them to actions at different levels of the health system. The indicators are closely related to the objective of political commitment. Nevertheless it is essential to measure these principles explicitly because of their vital role in the strategy development and implementation.

The referring to and acting according to the guiding principles can be perceived as government statements establishing goals, including plans for attaining them and guiding implementation of comprehensive programmes.

The potential impact if following these principles is so great that it is considered essential that governments accept and address the link between these rather theoretical terms and the fundamental improvement of the health status, the development and the life satisfaction of children and adolescents. This is an objective that goes beyond the simple existence of health promotion, prevention and control policies. It defines standards that must be met in order to have *complete* national strategies that address the issue of child and adolescent health according to a holistic paradigm. This way some of the subjective judgement of political commitment is eliminated and it becomes clear which countries that have a *complete* strategy and thus also where technical support within the strategy development or review is most needed.

Indicator 2.1: Youth participation
Definition: Participation of young people in the development of a national strategy

What it measures: Measures whether the target group has had the opportunity to influence and take part in the development of a national strategy. Youth participation can help achieve better outcomes from the implementation process for both the young people and the adults involved in the process and for the target group of young people and the communities as a whole. Organizations that have embraced youth participation believe it benefits the young people, makes the program more relevant and credible, and strengthens the program's ties to the larger community.

Indicator 2.2: Explicit and systematically dealing with different age groups in a national strategy
Definition: The explicit and systematic addressing of prenatals, neonatals (0–1 year), young children (1–4 years), older children (5–9 years) and adolescents (10–19 years) in a national strategy.

What it measures: Measures to what extent the life-course approach is being used and respected in the development of a national strategy. Health throughout life (a life-course approach) focuses on the health challenges associated with each stage of development from prenatal life to adolescence, such as infancy, early childhood and puberty.

Indicator 2.3: Assessing and addressing inequities between different population groups
Definition: The explicit and systematic assessment of health gaps within different population groups of the society and dealing with such gaps in a national strategy for child and adolescent health and development.

What it measures: Measures whether the principle of equity is respected in the development of a national strategy. The mentioned population groups could be socially disadvantaged groups, economic groups, ethnic groups and gender groups and any other group that is likely to need special attention in the society.

Objective 3: Child and Adolescent Health Services
Improve the provision of preventive and curative child health services

This is the only objective that deals directly with the output of the implementation of the strategy. At this point of the implementation it is difficult to measure output, but since the one indicator under this objective is also closely related to the guiding principle of equity, it is still meaningful to include it in an evaluation of the implementation phase. The objective allows for a more in-depth evaluation of different population group's access to different child health services and thus the information is useful for identifying subpopulations that are not accessing child health services proportionally so that targeted policies that deal with these groups can be introduced in national strategies. The future aim is that this objective will reflect the strengths and the limitations of the provision of services in both the primary and the secondary sector in getting through to the entire population. Over time this will hopefully allow for further consideration of the suitability of the current national strategies in particular demographic contexts. The challenge in this regard is to measure what is *not* reported – namely which young individuals that do *not* access the preventive and curative health care. The future challenge in this regard would be to identify specific characteristics that these individuals might have in common and the reasons why certain population groups are less likely to have access to the care that they need and they have a right to receive than others.

Indicator 3.1: Knowing the gaps in accessibility of child and adolescent health services
Definition: Detection and dealing with substantial gaps in the accessibility of current CAH services.

What it measures: Measures the detection of the gaps in the access to child and adolescent health services according to different demographic areas of the country – e.g. gaps between urban and rural areas. Furthermore it measures to what extent interventions and action are being established to address the identified gaps as a result of the European strategy.

Objective 4: Information Systems
Ensure that specific information systems are in place to support child and adolescent health and development

An information system that allows the carrying out of detailed situation analysis, assessment of overall program outcome and national as well as international comparison of data is a key element in health promotion. Indicators and information required for a holistic approach to children's health and development should be readily available at the desktop of the relevant decision makers. There is obviously a common aim despite of the different driving forces in the provision and use of child health information: To have access to useful and reliable information, when improving child and adolescent health and development policies, programmes and action plans. The information in itself will also serve as advocacy. Health ministries in several countries might not be taking into account the importance of collecting data on several factors that are maybe not directly related to health status measures but to health process and determinant measures. But a holistic mapping of child health and development will make the different national and international institutions and organizations able to direct their voices to the right people and show evidence to their argumentation. This is the only way of making the right kind of advocacy for a population that in a large extent is not able to express its own interests and concerns.

The amount of information collected should be a result of a process where the main objective is to identify current weak areas and deficiencies within the child health status and the determinants of child and adolescent health. But at the same time it should also seek to minimize the need for extra data collection resources. The set of indicators that form the basis of the data collection should strive at giving the greatest focus to those children most at risk of compromised health, but at the same time it should also be in favour of the ongoing surveillance affecting the whole child population. At least four main areas of information must be covered if the development of a national strategy should be based on a holistic approach:

- demographic and socioeconomic determinants of child health
- child health status and well-being
- determinants of child health, risk and protective factors
- child health systems and policy.

Obviously the indicators of such a database should be grounded in research that demonstrates a strong correlation relationship between the topic of the indicator and child health and development.

Indicator 4.1: Existence of a national database of child and adolescent health data
Definition: Existence, revision and improvement of a national CAH database and appraisal of the extent of measurement and monitoring of the most appropriate indicators.

What it measures: The state/completeness of the existing the information systems and the need for a reshaping of them in such a way that the indicators and information required for a holistic approach to children's health and development is readily available to relevant decision makers. The aim of this is to make a useful and reliable tool in the improvement of child and adolescent health and development strategies, policies, programmes and action plans.

Indicator 4.2: Collection of disaggregated data
Definition: Collection and existence of data in a disaggregated form.

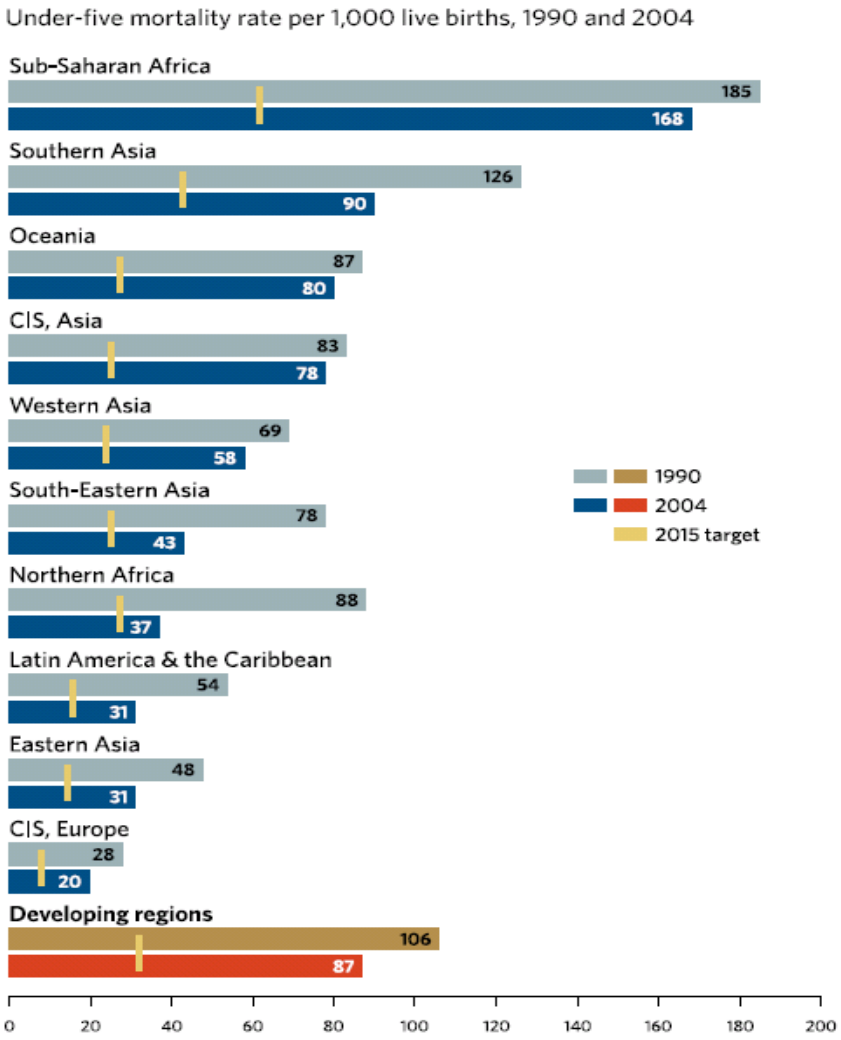
What it measures: The CHILD project recommends three essential strata in most of the indicators: Gender, age groups and socioeconomic groupings. The indicators which do have data on these different strata are still limited to the child health status measures in most countries. It is crucial to collect, process and assess data separately on the early age groups (e.g. 0–4 year-olds, 5–9 year-olds, 10–14 year-olds and 15–17 year-olds), as these are very distinct subgroups, with different dependencies and health determinants. The life course theory confirms this need for detailed age grouping by focusing on sensitive and critical periods of early life. Looking upon children and adolescents as one big population group is sometimes necessary to make a general strategy, but one should always take into consideration the different states in childhood and adolescence. Regarding the gender breakdown of the indicators this is even more obvious. In some countries children are treated differently according to their gender and this of course influences the health patterns and it could result in a gender gradient in the reported data. Breakdown by socioeconomic groupings is important when mapping the inequalities in the societies and finding out how big a percentage of the children in the Member States actually live in poverty or in families with low score on the family affluence scale (FAS), based on family car ownership, bedroom occupancy, family holidays and computer ownership. The problem is that we do not exactly know in what way this influences the remaining child health indicators and the overall health of the child and we are not able to verify this until data on each relevant indicator can be broken down by e.g. socioeconomic grouping.

Objective 5: Declarations and Conventions
Ensure the incorporation of the Millennium Development Goals and the Convention of the Rights of the Child in the development of the European Strategy

Overall, the goal of the strategy is to enable children and adolescents in the European Region to realize their full potential for health and development and to reduce the burden of avoidable disease and mortality. The intention is to encourage healthy growth and development and to reduce illness and mortality, not only among children and adolescents now, but also among the adults of the future. An investment in the healthy development of young people today will, by definition, contribute to economic prosperity tomorrow. In working towards the objectives of the strategy, Member States will be helping to fulfil their commitment to achieving the Millennium Development Goals (MDGs). The MDGs include reduction of child mortality through prevention, care, treatment and support, and the mobilization of additional resources from national, bilateral, multilateral and private sources. This is not automatically included in a national child health strategy and a child health strategy can only contribute systematically to the MDGs by considering these goals and including them in the development of action plans supporting the implementation of a national strategy. The causes and rates of death in children vary widely across the Region. In particular, eastern countries have higher mortality from respiratory and infectious diseases, injuries and poisoning, which create a different pattern than that of the mortality of adults. In the western countries, mortality from these causes is already very low. Children's disease patterns in the western countries are therefore more characterized by non communicable diseases, such as asthma and allergies, diabetes, obesity and

neuropsychiatric disorders. These diseases clearly do not cause much child mortality in the western countries, but they contribute to the mortality in the longer course of life of many adults. Mortality as a consequence of vaccine-preventable diseases remains a worry across the Region. As the child mortality patterns in the Member States of the European Region are extremely diverse, evidently addressing the child mortality is not equally relevant to all countries. Figure 1 illustrates the under-five mortality rates from respectively 1990 and 2004 in the different UN regions. The European mortality rates are the lowest of them all, but this does not mean that effort is not being put into this area. WHO EURO is in collaboration with UNICEF planning to develop country specific child survival action plans in order to tailor the interventions as much as possible. These action plans will be developed according to the guiding principles of the European Strategy and consequently form part of a national strategy in the specific Member States.

Figure 1: The under-five mortality rates from respectively 1990 and 2004 in the different UN regions



Source: http://unstats.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf

Health is a fundamental human right for every child and adolescent in the Region. The right to enjoy the “highest attainable standard of health” is enshrined in the Convention on the Rights of the Child and is the moral and legal basis for striving towards an equitable distribution of health.

The opportunity for our children and adolescents to grow and develop in a family setting and a social and physical environment that provide equitable access to health should be a fundamental policy objective for all countries. The strategy encourages governmental actions and policies promoting and protecting children's rights. It seeks to ensure that all existing and new legislation and judicial practice is compatible with the country's international obligations, monitor governments' actions, policies and budgets and involve the community – including children – in relevant decision making.

Indicator 5.1: Contribution of the strategy to the Millennium Development Goals
Definition: Explicit addressing of the MDGs in a national strategy. A qualitative indicator that notes whether the specific goals, in particular, or the MDGs, in general, are stated priorities in the country by being explicitly addressed in a national strategy.

What it measures: Provides an indicator of government support and engagement in reaching the MDGs and integrating them in the national strategies for child and adolescent health and development. The existence of MDGs as a stated priority does not necessarily signify strong government and partner support for an effort towards reaching the Millennium Development Goals. However, the absence of any mention of MDGs may be a signal of important deficiencies in support of and engagement in the promotion of child and adolescent health and development. The Declaration should be the main benchmark and inspiration for all government action. In its reviews of States' reports, the Committee urges all levels of government to use the Declaration as a guide in policy-making and legislation.

Indicator 5.2: Contribution of the strategy to the Convention of the Rights of the Child
Definition: Explicit addressing of the Rights of the Child in a national strategy. A qualitative indicator that notes whether the specific rights of the Child, in particular, or the Convention, in general, are stated priorities in the country by being explicitly addressed in a national strategy.

What it measures: Provides an indicator of national governments commitment towards protecting and ensuring children's rights by agreeing to undertake the obligations of the Convention, since governments have agreed to hold themselves accountable for this commitment before the international community. States parties to the Convention are therefore obliged to develop and undertake all actions and policies in the light of the best interests of the child and it is consequently crucial to integrate the convention in the national strategies.

Objective 6: Human Resources
Ensure existence of required staff, specialized skills and professional knowledge when developing and implementing the European Strategy

It is important that staff at different levels in the health system has the necessary skills, attitudes and knowledge to implement and sustain the strategy. For the overall development of the strategy and the achievement of specific objectives it is necessary to address the issue of human resource capacity in a fundamental way. Local initiative, autonomy, participation and empowerment imply that the necessary skills and technical knowledge to carry out a planning process are extent in the group of national stakeholders.

This objective focuses on the availability of human resources needed to direct and manage child and adolescent health interventions and the existence of effective coordination mechanisms among key agencies given the technical complexity of child and adolescent health approaches and case management. It contains information on the organizational and human resource capacity to perform and achieve the objectives outlined in the strategy. Ideally, the needs and interests expressed at the national level would trigger the entire implementation of the strategy.

But because of the concentration of resources at other levels the process too often starts as a top-down process when a trusting collaboration is being established. When WHO is involved in selected implementation and evaluation functions with the national stakeholders, it has to be accompanied by technical assistance and information in order for the national stakeholders to carry out these functions themselves and tailor the strategy to the national needs and demands. This also goes for the earlier assessment as well as the planning processes. After the provision of technical support, the national stakeholders will hopefully have developed its own resources to maintain the program or to move on to other identified problems in the field. One of the most important elements in the provision of technical support is the national workshops introducing the strategy to the individual countries. The main objectives of these workshops have been:

- presenting the WHO European Strategy on Health and Development of Children and Adolescents in Europe to the Ministry of Health and other important stakeholders in the country responsible for child and adolescent health and development;
- evaluating the actual situation, needs, problems, policy and strategies related with child and adolescent health and development in the country;
- evaluating National Child Health Programs and other projects on child health;
- identifying the sources and the stakeholders needed for adopting the WHO European Strategy on Health and Development of Children and Adolescents within the country context; and
- identifying the possibilities of implementation of this strategy and identifying barriers.

The intention of the workshops is to:

- predispose the Member States to the implementation of the strategy by arousing national awareness, concern and initiative;
- enable the carrying out of the implementation of the strategy by providing technical assistance to those who wish to take initiative; and
- reinforce the implementation of the strategy by generating systems of data that provide feedback on progress and accomplishments.

Indicator 6.1: Capacity building workshops
Definition: Whether any workshops on national child and adolescent health strategies have been carried out as a result of the European Strategy and the outcomes from such workshops.

What it measures: The workshops should be related to the evaluation of actual situations, needs, problems, policies and strategies related with child and adolescent health and development in the countries. Outcomes of the workshops would be an overview of the existing policies and strategies in the area of child and adolescent health, including identification of gaps and recommendation for future directions for a plan of activities involving all stakeholders.

The questionnaire

The questionnaire was based on the identified objectives and indicators and they therefore work as empiric indicators of the key concepts that we wish to examine. The item construction was focused around the fact that the items should be neutral, well-defined and easy to understand and the question should not be leading in any way. Most questions should be closed in order to ensure the generalizability of the data meaning that the response is made by ticking off one of the pre-indicated responses. Finally the items were constructed according to the method of data

collection. Knowing on beforehand that the data was meant to be collected by mail we had to make sure that the items did not require any further explanation from our part before completing the questionnaire.

The questionnaire was designed in a simple and relatively short version in order to ensure as high a response rate as possible. It consists of 30 items out of which only four where directly open ended questions. Each item was constructed in a way that made it possible to add any comments to the question. We were happy to ascertain that most of the respondents used this opportunity to make additional comments and the qualitative analysis of this report is based partly on these comments and partly on the answers to the open ended questions.

The six different themes in the questionnaire are the objectives of the evaluation that emerged from the conceptualisation and they form the overall structure of the questionnaire. It starts out going through policies and political commitment in the national context. Then it moves on to the principles of the strategy, the provision of health services and collection of data with the aim of getting an overview of whether the strategy is being brought into play in some of the current activities. The fifth theme regarding the international conventions and declarations places the implementation of the strategy in a broader political context and the final theme, capacity development, assesses the progress of the initial implementation phase from a more tangible point of view. Appendix 1 shows the framework of measurement. It gives an impression of the way that it is possible to measure the achievement of the stated objectives of the implementation of the strategy by defining indicators and formulating one or more items that all correspond to one specific indicator and one specific objective.

Recognizing that our position as observers is very different from health professionals in each of the Member States, we wished to obtain feedback from a national point of view in order to modify the questionnaire according to the meanings and understandings that national counterparts ascribe to the items in the questionnaire. The questionnaire was pre-tested in Slovenia and modified according to their comments on the understanding of the questionnaire and advise regarding other practicalities such as time required for completion of the questionnaire, the most suited person in the Ministry of Health for completion of the questionnaire, need for external consultation in other sectors etc.

Data treatment

The questionnaire was sent out by mail to the technical addresses in the Ministries of Health in the 53 Member States. The responses to the closed questions were coded according to the response categories. After entering the data a data cleaning was carried out to make sure that data that seemed strange or did not make sense was double checked and modified in case there had been a mistake in the first data entry.

The quantitative analysis of the data based on the 26 closed questions was carried out partly as a descriptive analysis in order to get an overview of the answering patterns and partly as a correlation analysis in order to get an impression of which of the variables and questions that were related to each other. In order to answer the problem statement it was especially relevant to look at the relations between a certain activity or organizational change being carried out and whether this activity or change is being carried out because of the strategy.

The data derived from the 26 closed questions was entered in SPSS 14.0. The file consists of a data view with all of the coded answers entered and a variable view where all of the required information for each variable can be found. A few variables were added to the data set to be able to carry out the necessary analysis of data in different clusters. The countries were consequently divided into clusters according to membership of the European Union and financial support from WHO to child and adolescent health.

Data analysis

Descriptive data outline

The questionnaire was sent out to all Ministries of Health in the 53 Member States of the European Region. 23 Member States completed and returned the questionnaire both in 2006 and 2008. Half of the Member States that returned the questionnaire were EU countries. 10 of the countries are countries that receive financial support from WHO Europe at the moment. Table 1 shows the Member States that completed and returned the questionnaire both in 2006 and 2008 thereby enabling the follow up on the implementation of the European Strategy for Child and Adolescent health and Development in these 23 countries.

Table 1: Member States that completed and returned the questionnaire both in 2006 and 2008

Albania	Italy
Armenia	Kyrgyzstan
Belarus	Lithuania
Czech Republic	Montenegro
Denmark	Netherlands
Estonia	Poland
Finland	Slovakia
Georgia	Spain
Greece	Turkey
Hungary	Ukraine
Ireland	Uzbekistan
Israel	

Table 2 shows the frequencies of the different responses to the questions in the questionnaire 2006 and 2008, red and blue numbers respectively. The category *missing* includes non-applicable as well. The total 100% corresponds to the 23 countries that completed and returned both questionnaires, meaning that the countries that did not return the questionnaire are not forming part of the analysis. In the following chapter each of the results in the below table will be described more thoroughly.

Table 2: Frequencies of the distribution of responses to each question

1	**Policies and Political Commitment**				
Item nr.	**Question**	**Yes**	**Partially**	**No**	**Missing**
1.1	Initiated review/development/implementation strategies based on the European Strategy	60.9% 52.2%	13.0% 17.4%	26.1% 26.1%	0.0% 4.3%
1.2	Direct technical support from WHO in the development of the national strategy	26.1% 39.1%	26.1% 13.0%	43.5% 43.5%	4.3% 4.3%
1.3	Existence of a multisectoral workgroup on CAH and development	60.9% 65.2%	0.0% 13.0%	39.1% 21.7%	
1.3.1	Establishment of multisectoral work group as a result of the European Strategy	4.3% 26.1%	21.7% 26.1%	47.8% 30.4%	21.7% 17.4%
1.4	Governmental budgetary allocations and/or reallocations of dedicated resources for CAH as a result of the European Strategy	8.7% 17.4%	30.4% 34.8%	56.5% 47.8%	4.3% 0.0%
1.5	Involvement of NGOs in the review/development/implementation of a national strategy	39.1% 52.2%	8.7% 13.0%	47.8% 34.8%	4.3% 0.0%

2	Respecting the Four Guiding Principles				
Item nr.	**Question**	**Yes**	**Partially**	**No**	**Missing**
2.1	Involvement of youth in the review/development/implementation of the strategy	30.4% 39.1%	26.1% 13.0%	34.8% 47.8%	8.7% 0.0%
2.1.1	Involvement of youth in the review/development/ implementation of the strategy as a result of the European strategy	8.7% 17.4%	13.0% 26.1%	39.1% 21.7%	39.1% 34.8%
2.2	Addressing the different age groups in a national strategy as a result of the European strategy	21.7% 30.4%	21.7% 8.7%	47.8% 34.8%	8.7% 26.1%
2.2.1	Addressing prenatal children systematically and explicitly in a national strategy	65.2% 73.9%		8.7% 0.0%	26.1% 26.1%
2.2.2	Addressing children between birth and 1 year old systematically and explicitly in a national strategy	65.2% 69.6%		8.7% 4.3%	26.1% 26.1%
2.2.3	Addressing children between 1 and 4 years old systematically and explicitly in a national strategy	56.5% 65.2%		13.0% 8.7%	30.4% 26.1%
2.2.4	Addressing children between 5 and 9 years old systematically and explicitly in a national strategy	52.2% 65.2%		21.7% 8.7%	21.7% 26.1%
2.2.5	Addressing children/adolescents between 10 and 19 years old systematically and explicitly in a national strategy	56.5% 65.2%	0.0% 4.3%	21.7% 4.3%	26.1% 26.1%
2.3	Inequities among different population groups	47.8% 73.9%	17.4% 8.7%	26.1% 13.0%	8.7% 4.3%
2.3.1	Addressing different population groups in the national strategy	30.4% 52.2%	26.1% 17.4%	17.4% 17.4%	26.1% 13.0%
2.3.3	Addressing different groups as a result of the European strategy	13.0% 26.1%	8.7% 13.0%	39.1% 30.4%	39.1% 30.4%

3	**Provision of Preventive and Curative Child Health Services**				
Item nr.	**Question**	**Yes**	**Partially**	**No**	**Missing**
3.1	Gaps in accessibility of CA health services	26.1% 30.4%	17.4% 26.1%	43.5% 34.8%	13.0% 8.7%
3.2	Addressing identified gaps as a result of the European strategy	8.7% 26.1%	17.4% 21.7%	43.5% 34.8%	30.4% 17.4%
4	**Standardized Collection of Data**				
4.1	Existence of a national database of relevant child and adolescent health data	52.2% 52.2%	26.1% 39.1%	17.4% 8.7%	4.3% 0.0%
4.1.1	Review/improvement of current national database as a result of the European strategy	0.0% 8.7%	21.7% 21.7%	43.5% 39.1%	34.8% 0.0%
4.1.2	Database containing the same indicators as the CHILD database	17.4% 21.7%	39.1% 39.1%	8.7% 4.3%	34.8% 34.8%
4.2	Collecting disaggregated data as a result of the European Strategy	4.3% 17.4%	17.4% 26.1%	65.2% 47.8%	13.0% 8.7%
5	**Respecting International Conventions and Declarations**				
5.1	Contribution of MDGs to the strategy	21.7% 34.8%	34.8% 21.7%	30.4% 34.8%	13.0% 8.7%
5.2	Contribution of Convention of the Rights of the Child to a national strategy	60.9% 69.6%	13.0% 8.7%	13.0% 17.4%	13.0% 4.3%
6	**Capacity Development**				
6.1	Capacity building workshops as a result of the European strategy	21.7% 52.2%	17.4% 8.7%	52.2% 39.1%	8.7% 0.0%
Additional information on respondents					
	EU countries	52.2% 52.2%		47.8% 47.8%	
	Countries that receive financial support from CAH	39.1% 39.1%		60.9% 60.9%	

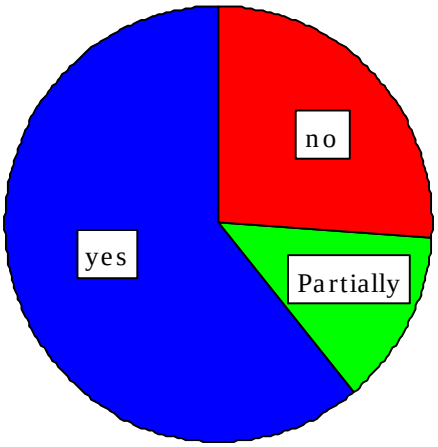
Descriptive analysis on each objective

In the subsequent chapter the baseline and follow up results will be described by objectives. First of all it illustrates the status of the implementation of the European Strategy in the WHO European Region. In addition to this it also demonstrates the developed measurement framework in practise. The comments that were provided by the persons that completed the questionnaire have been taken into account in the below description of the results. The written out comments can be found in appendix 2.

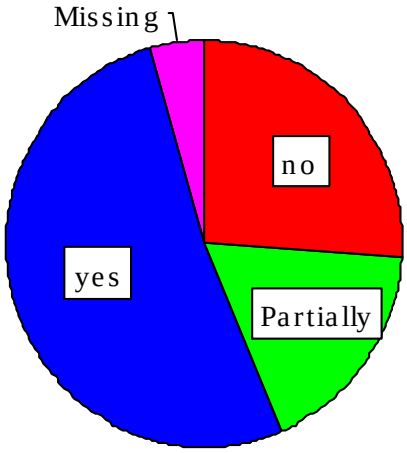
Objective 1: Increase the political commitment towards the development of national strategies

Indicator 1.1: Initiated development and implementation of a national strategy

Initiated development baseline



Initiated development follow up



More than half of the countries state that a review/development/implementation of a national strategy for child and adolescent health and development has been initiated. Initiating the review, development and implementation of a national strategy indicates that the motivation and willingness for improving child and adolescent health and development in these countries must be relatively high. It is notable that fewer countries state that they have initiated the development of a national strategy based on the European strategy in 2008 compared to 2006. This might be due to a standstill of the development process in some Member States.

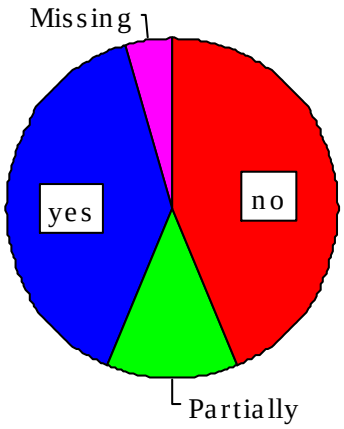
According to the comments that were given to this question it is obvious that a separate, national strategy for child and adolescent health does not exist in many countries, but that the issue of child and adolescent health is covered in other national strategies, such as strategies on public health, HIV/AIDS, adolescent health, neonatal health, mother and child health and other national policy planning documents. Still the European Strategy has inspired the review of already existing plans to a large extent. Other countries simply state hat they are in the process of evaluating whether there is a need to establish a new national strategy in the area of CAH. As part of these considerations, the European Strategy is being considered. Another important remark is that some countries have very independent regions which themselves have developed

and implemented a regional strategy for child and adolescent health and development. This of course makes it difficult to monitor the progress at a national level.

Indicator 1.2: Provision of Technical Support from WHO

Technical WHO support baseline

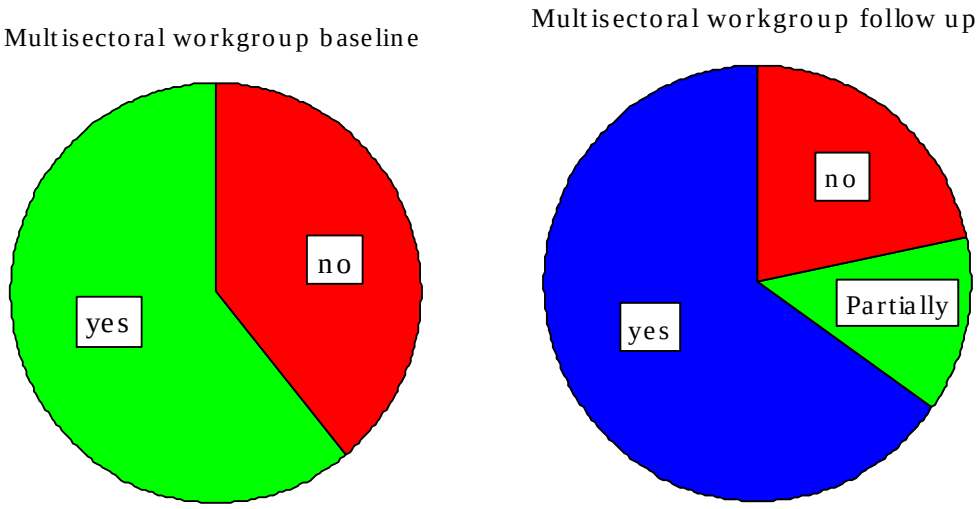
Technical WHO support follow up



At the point in time they completed the baseline questionnaire, 26% of the countries stated that they had received direct technical support from WHO. At follow up this number had increased to 39% of the countries. This of course does not give us any information about the quality of the technical support provided, which can only be indicated by the way that this variable is interrelated to other variables (see page 32-35).

The technical support that the countries had received was specified as information support, email correspondence, visits, conversations and materials. Some countries stated that they had been offered the support, but that the offer had not yet been taken up.

Indicator 1.3: Existence of a Multisectoral workgroup



Of the countries who reported back on the baseline questionnaire, 61% answered that a multisectoral taskforce already existed in 2006. This number had increased to 65% in 2008 and furthermore a substantial part of the countries report that a group partially exists now. There is no difference between CAH activity countries and countries without CAH activity in this regard. It is important to note that almost 40% answered *no* to this question in 2006 whereas only about 20% answered *no* in 2008. Consequently group of countries that need to establish such a taskforce is now much smaller, which is positive since this is a basic criterion for the development of a cross-sectoral strategy.

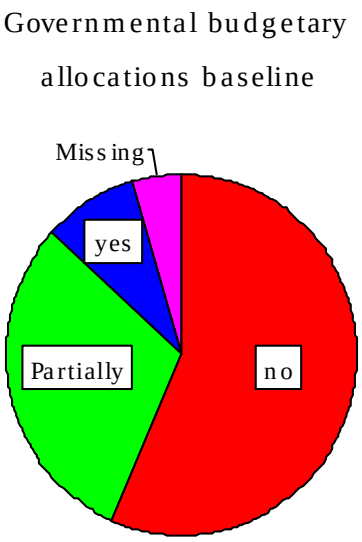
It is very common that several smaller, specific workgroups in more restricted areas such as health care, injury prevention, obesity prevention etc. exist in the countries. Also to a large extent you find regular collaborations between different sectors without the establishment of an intersectoral workgroup as such. These are all valuable assets to the implementation of the strategy, but they are naturally more difficult to unite in one common strategy approach.

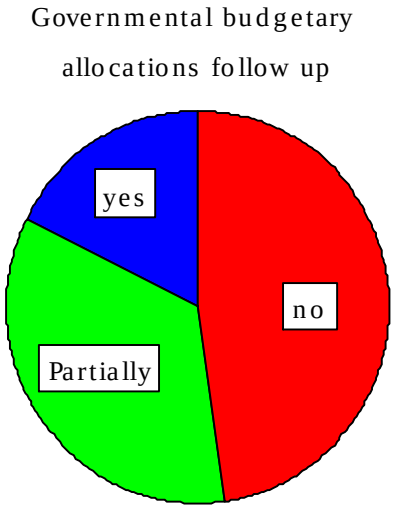
It looks as if a multisectoral taskforce for the most part has not been established as a result of the European strategy. This means that either the taskforce was already there independently of the European Strategy or it has not been established at all. Please note that a lot of countries did not answer this question at all. Therefore we should be careful with the conclusions in this regard.

In the box below all the mentioned institutions, sectors and organizations mentioned as part of the taskforce are listed.

Sectors	Health, Mass media, Environment, Social Affairs; Education and, Agriculture, Culture, Interior, Finance, Justice, Communications/Public relations
Other institutions or organizations	Organizations for Protection of the Rights of the Child, Statistic Institutes; Youth organizations. Research Institutes, voluntary organizations, parent organizations; Scientific Associations etc.

Indicator 1.4: Governmental Budgetary Allocations for Child and Adolescent Health and Development

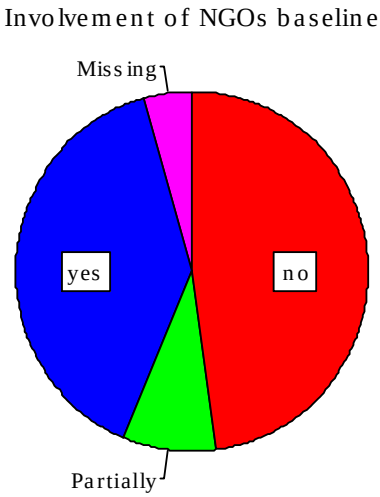


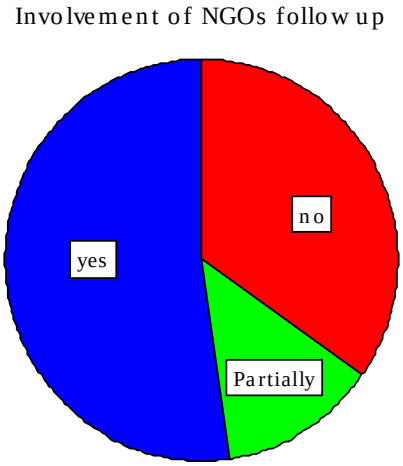


Only 8.7% of the countries claimed that there have been governmental budgetary allocations/reallocations of dedicated resources for CAH in 2006. In 2008 it seems that substantially more countries dedicated resources for CAH. 17.4% of the countries now claim to have such budgetary allocations. This basically means that the work with the strategy is still being carried out without any additional governmental expenses in most countries. However little by little the financial resources are being directed towards this area.

Most budgetary allocations are neither directly dedicated to nor a direct result of the implementation of the European Strategy. However dedicated special, governmental funding for child and adolescent health has been dedicated as part of other national projects and programmes that are indirectly related to the implementation of the European Strategy. A positive tendency is that there are being made several interdisciplinary allocations in the area of children's and adolescents' health, development and welfare.

Indicator 1.5: Participation of NGOs





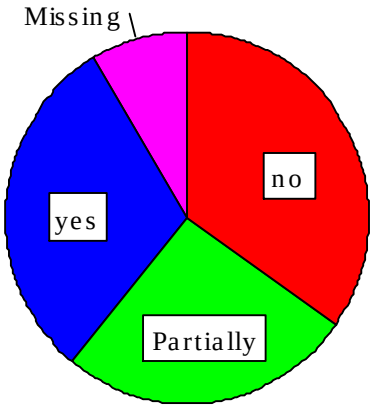
In 2006 most countries claimed that they did not involve NGOs in the development of a strategy– more specifically 48% of the respondents answered no, while only 39% answered yes. Now, in 2008, this picture has changed completely. More than half of the countries (52%) stated that they have involved NGOs in the development or review of a national strategy. These results are fairly encouraging, since this number reflects all of the countries that have actually started the review/development/implementation of a national strategy.

NGOs have also been involved in the development of other national plans and strategies – e.g. the Strategy of the Rights of the Child and Public health Strategies. This means that some countries have plenty of experience in regard to the involvement of NGOs in developing policies. Involvement of NGOs is being associated with taking a holistic approach to child and adolescent health. Including NGOs that work with e.g. environment and life style enables countries to work beyond a strictly traditional, medical paradigm. Involvement of NGOs ranges from simply inviting NGOs for relevant discussions to including them in decision-making activities.

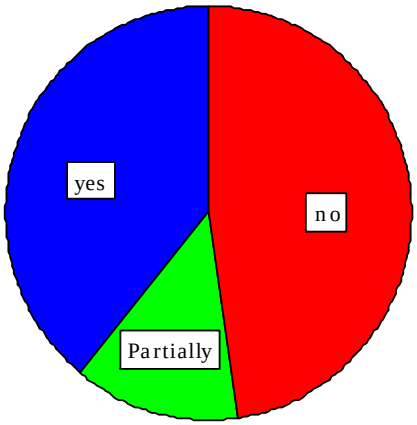
Objective 2: Ensure the integration of the guiding principles of the European Strategy

Indicator 2.1: Youth participation

Participation of youth baseline

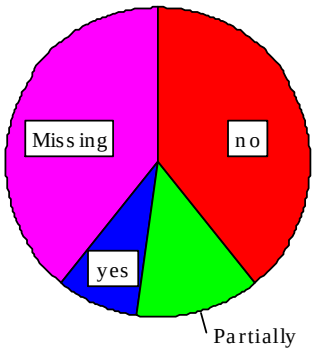


Participation of youth follow up

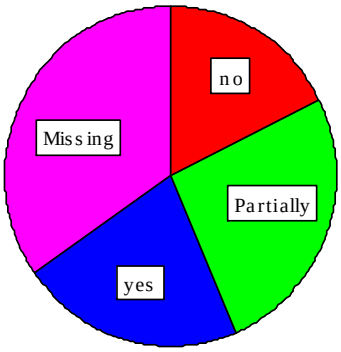


In 2006, 30% of the countries replied that youth had been involved in the development/review/implementation of the strategy. In 2008 this number increased to 39%. The involvement of youth consequently still appears to be less than the involvement of NGOs, but nevertheless quite high taking into consideration that only half of the countries actually initiated the implementation of the strategy. Youth is to a large extent being involved in the process through NGOs such as Children's Parliament or youth movements. E.g. the Macedonian health professionals are planning to carry out focus group discussions over the final version of the national strategy document with young members of NGOs. Other forms of involving youth are through student councils. Generally there seems to be a lot of activities going on in the region in order to involve young people in organizations working for specific interests, but there is a lack of coordination and very limited power in regard to the policy planning at national level, which means that youth involvement, tends to stay at a local level. Relevant entry points for youth participation are regarded as peer-to-peer education and youth friendly health services.

Participation of youth
as result of strategy baseline

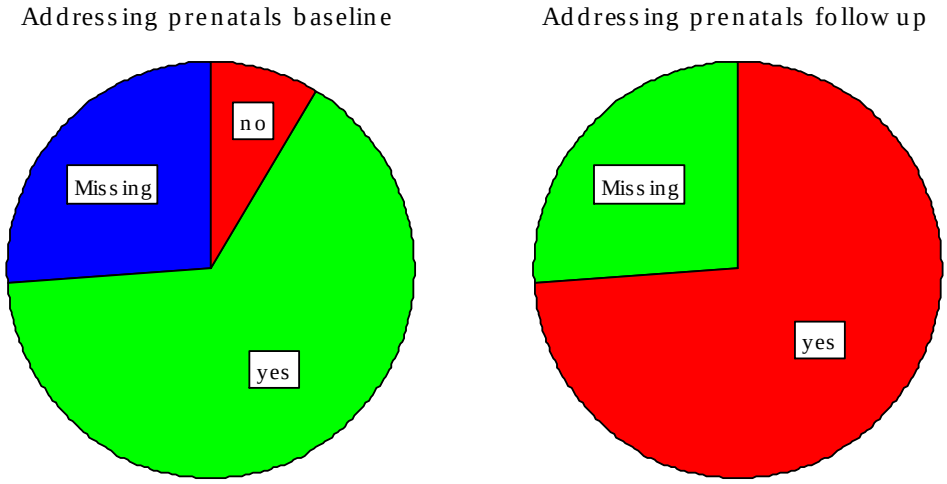


Participaton of youth as
result of strategy follow up

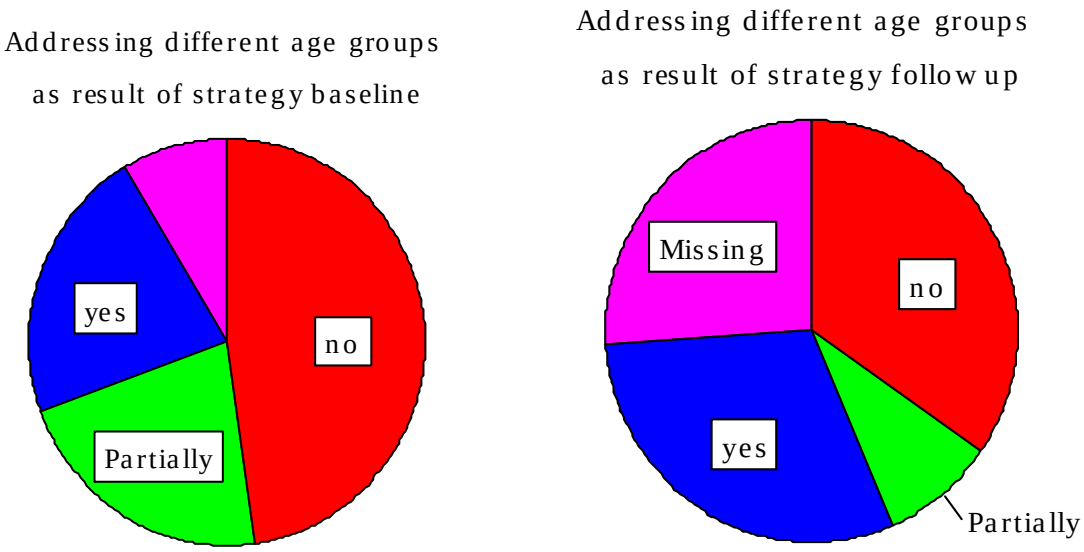


It is interesting that only a very small part actually has involved youth as a result of the strategy. This might indicate that the motivation and the means for involving youth is something that is already present in the Member States and that youth has been involved regardless of the European Strategy. However it is worth noticing that the number of countries that have involved youth as a direct result of the strategy has almost doubled in two years from 9% to 17%. In the comments for this question it was pointed out that the value of the European strategy is to point out the principle to involve youth in the discussions and planning processes concerning their health and development.

Indicator 2.2: Explicit and systematic dealing with different age groups in a national strategy



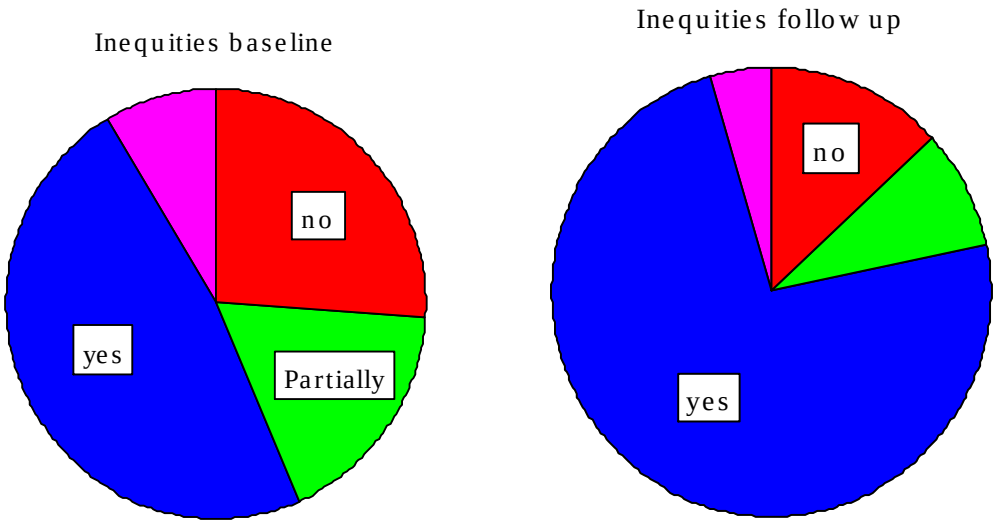
In 2006, 65% of the Member States address prenatal children in a national strategy. In 2008 even more countries claimed to address this age group explicitly in a national strategy – 74%. Very few answer that they do not address this group explicitly. Almost as many countries (70% in 2008) address the children between birth and 12 months explicitly in a national strategy, whereas the groups of children between 1–4, 5–9 and 10–19 years old are slightly less likely to be addressed explicitly in a national strategy – all 65% in 2008. Thus the population group of 5–9 year olds is now as represented in the national strategies as the other groups. In 2006 this age group was identified as the most neglected age group. IMCI deals with children up to 5 years old and the HBSC study deals with adolescents between 11 years old and 15 years old. This could be one of the reasons for a reduced focus on the 5–9 year-olds, which now seems to be compensated by the strategies. Mostly social policies are expected to cover and relate to different age groups. In the comments some countries point to the fact that it can seem contradicting to make an integral strategy and at the same time separate the age groups.



Clearly addressing a specific age group does not necessarily mean that this has been done as a result of the strategy. In 2006, 21% and 30% in 2008 answer that the mention of different age groups in a national strategy is a result of the European Strategy. Consequently this is something that is already part of an approach that has been established through earlier, national policies and strategies. Some countries state that age-specific activities are based on the concepts of other known projects such as Health Promoting Schools and Kindergartens.

In the comments several countries state that the life course approach has been guiding the explicit mentioning of each of the age groups.

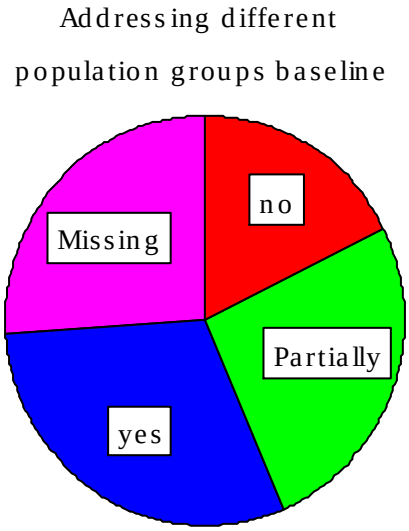
Indicator 2.3: Assessing and addressing inequities between different population groups

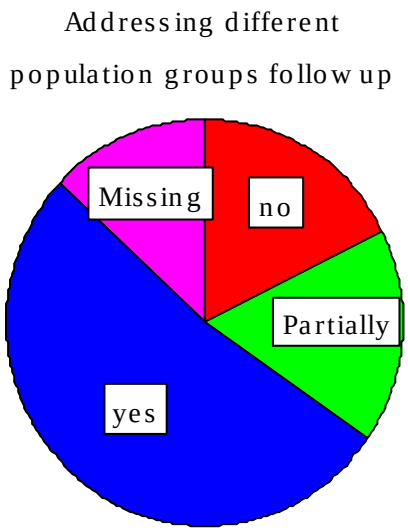


In 2006, 48% of the countries have detected substantial inequities in child and adolescent health. In 2008 as much as 74% answered yes to this question. These answers both provide us with the information that countries are carrying out assessments of health gaps within or between different population groups to a larger extent now than in 2006, and it also reveals that

substantial inequities have been found in 3/4 of the Member States. However there is still a relatively small proportion of the countries answering *no* to this question. Answering *no* can both mean that such assessments have not been carried out or that they did not show any inequities, which must be clarified through further evaluation.

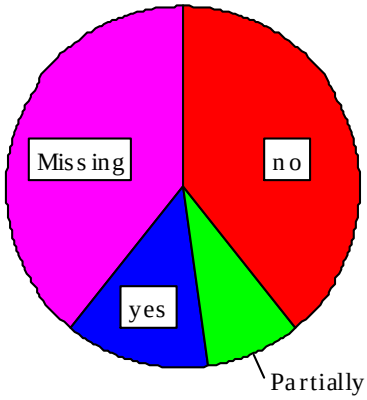
It has to a significant extent been stated that the general health of children is worse in rural areas than urban areas – more particularly in some countries there have been detected substantial inequities in mental health between children from rural and urban populations. Furthermore the infant mortality rates among minorities are mentioned explicitly as a big problem. In addition to this the HBSC study was pointed out as a good asset to assess inequities in some of the Member States, where it is being carried out. It is especially pointed out that children of mothers of low socioeconomic status or of teenage mothers are at higher risk than the average child. Orphans and disabled children were also mentioned as a part of the population that need special attention.



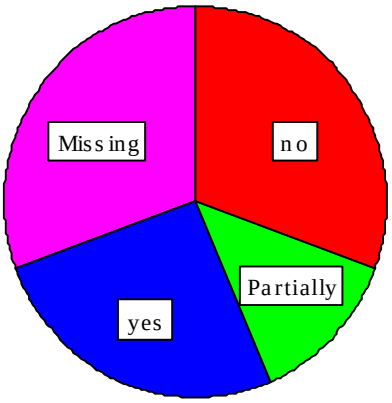


Unfortunately there was a lot of data missing in 2006 on the item measuring whether different population groups are being addressed in the national strategies. Still it is evident that in 2006 relatively few countries answered that they address the different population groups in a national strategy. In 2008 more than half of the countries (52%) can now state that they are addressing these groups in a national strategy. It was mentioned in the comments that these inequities to a certain extent are being addressed in more specific policy programmes, but that it is more difficult to address them in an overall policy document. Mostly socially related programmes are mentioned as the main documents addressing these issues.

Addressing different population groups as result of strategy baseline



Addressing different population groups as result of strategy follow up



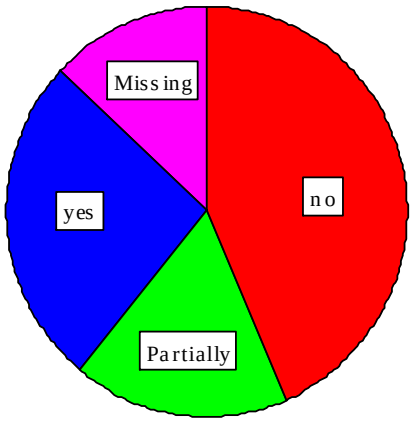
In 2006, of the countries that answered yes to the question regarding the mention of different population groups, half of them claimed that it was done as a result of the strategy. In 2008 the same picture is evident: Half of the countries that do this, state that it is done as a direct result of the European Strategy. This means that as opposed to involving NGOs, youth and mentioning the different age groups explicitly, the mention of different population groups in a national strategy – such as socially disadvantaged, ethnic, economic and gender groups – is actually already happening as a direct result of the European Strategy.

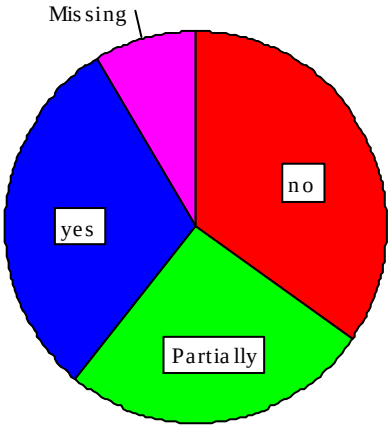
Objective 3: Improve the provision of preventive and curative child health services

Indicator 3.1: Knowing the gaps in accessibility of child and adolescent health services

Gaps in access to services follow up

Gaps in access to services baseline

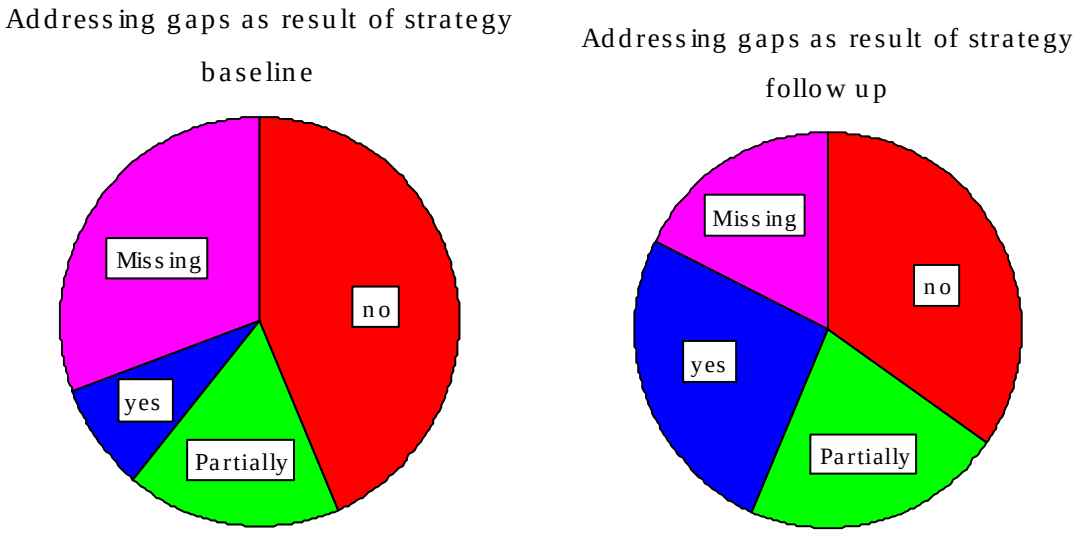




In 2006, 44% of the countries answered *no* to the question regarding the assessment of gaps in accessibility of CA health care, indicating that few assessments had been carried out that revealed substantial gaps in the accessibility of the current child and adolescent health services. In 2008 evidently more countries are answering partially or yes to this question, indicating that

such assessments are starting to be carried out in more than half of the countries. Further evaluation of the health care system will hopefully create more detailed knowledge on the gaps in the accessibility of services.

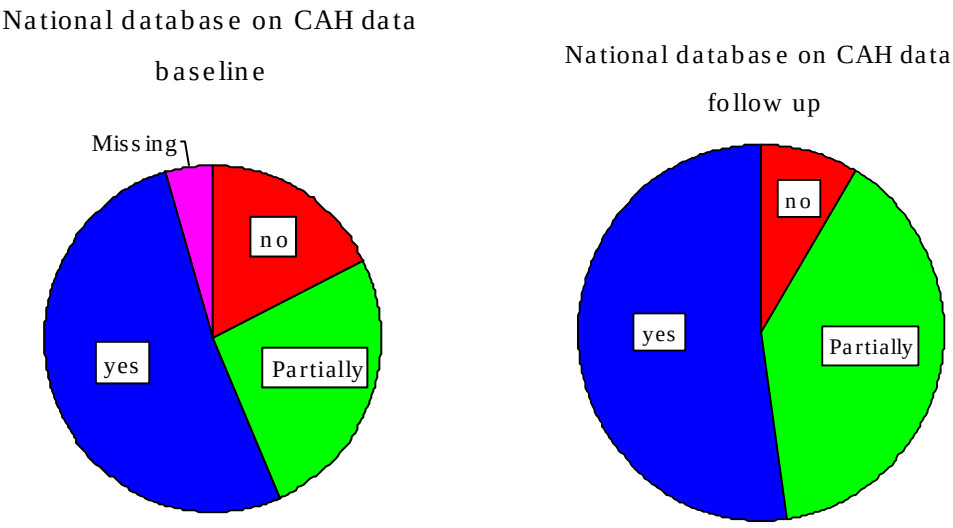
According to the comments provided in regard to the access to child and adolescent health services, there is no doubt that children living in urban areas have a poorer access to health services than children living in urban areas. New regional structures such as mobile health units are being created to deal with this gap in access to health care. Furthermore certain population groups such as Roma populations, refugees and displaced populations have difficult access to services and the lacking access to mental health care for children is also mentioned as a problem. In one of the Member States it is emphasized that young counselling services for reproductive health are almost explicitly being used by females. Finally the lack of specialists in certain areas is not surprisingly mentioned as a factor that is a barrier to children's access to appropriate health care.



In 2006 only 9% answered that substantial gaps in the accessibility of child and adolescent health care have been addressed as a result of the European Strategy, meaning that lees than half of the countries addressing identified gaps in accessibility of child and adolescent health services did so as a result of the European Strategy. In 2008 much more countries had addressed such accessibility gaps as a direct result of the European Strategy. Indicating that the added value of the strategy is substantial in this area.

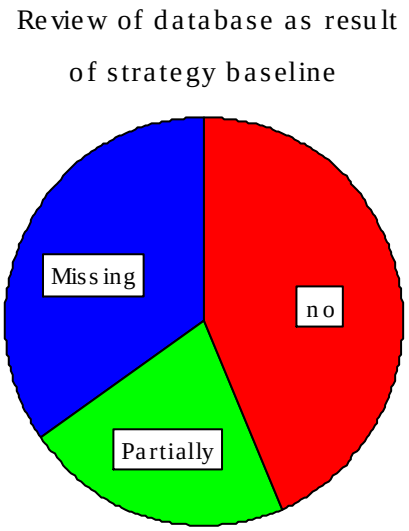
Objective 4: Ensure that specific information systems are in place to support child and adolescent health and development

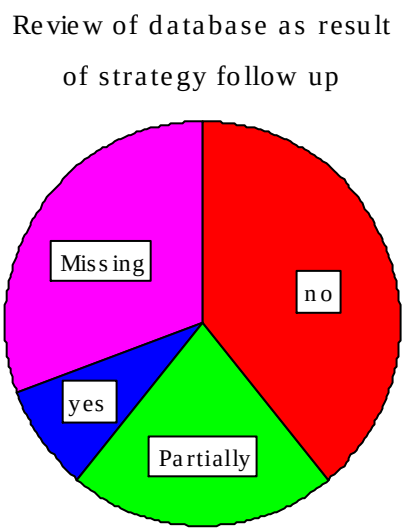
Indicator 4.1: Existence of a national database of child and adolescent health data



Both in 2006 and in 2008 half of the countries that completed the questionnaire claim that a national database of relevant child and adolescent health data exists. Furthermore, in 2008 39% claim that such a database partially exists. This means that most countries in some sense monitor child and adolescent health in a national database at this point in time. Further work should be done to collect information on the content of these databases to be able to use this data in the CHILD database and enhance the comparability of data between countries. Nevertheless, according to this item, apparently the national databases exist in many countries, which is useful information when carrying out assessments in order to prioritize the upcoming actions.

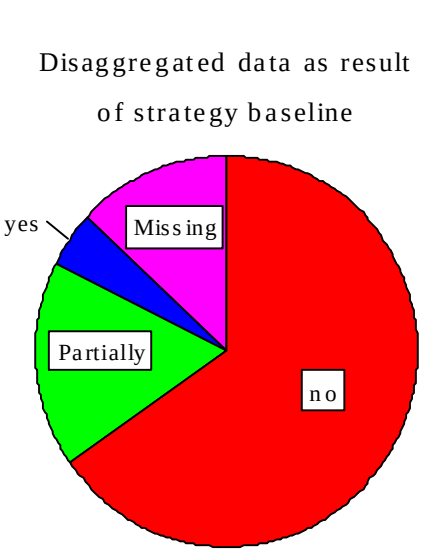
Morbidity and mortality data is collected in most countries and disaggregating of this kind of data is more and more frequently carried out. Data on socioeconomic conditions and on ethnic groups is still lacking. In some countries a database on child health does not exist as a single structure, but is integrated in other registers or databases. Data is in some countries collected accordingly to the WHO Health for All Database. Besides this the HBSC is used as a means to collect data every four years in some countries providing relevant information on social and behavioural issues in addition to the information on morbidity and mortality indicators. A positive comment was made from a couple of countries regarding the recent development of child well-being indicators.

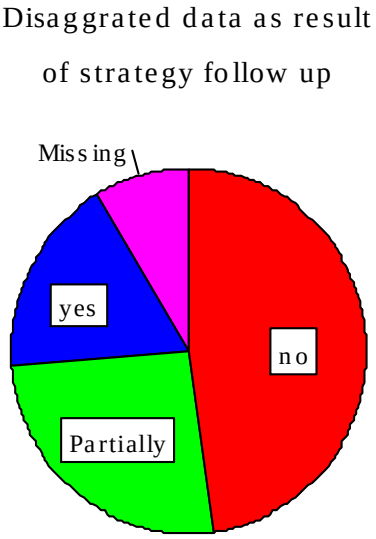




The strategy does not seem to have enhanced reviews of the national databases yet. In 2008 only 9% of the countries have reviewed their databases as a result of the European Strategy. The information tool that is closely linked to the European Strategy has obviously not been used for this purpose yet, which is a little disturbing as most countries should have reached this phase at this point in time.

Indicator 4.2: Collection of disaggregated data



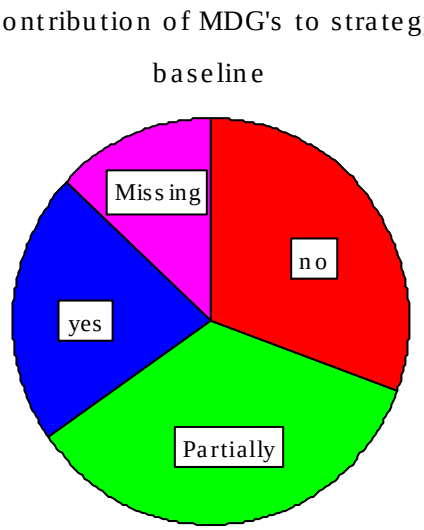


The importance of disaggregated data is essential when it comes to respecting the guiding principles of the strategy – both life-course, multisectoral and equity approach demand good health evidence within each of the relevant population groups. Furthermore in order to decide on which groups should be able to participate in the development/review of policies and strategies, it is important to know which population groups that need to be listened to the most. Need and participation should be interlinked and the key to identification of such groups is the disaggregating of data. But collecting disaggregated data is a big challenge and it is an extremely

demanding and time consuming work task. Therefore it is not surprising that this is an area where practically nobody can answer in a confirming way. Still more and more countries are answering yes or partially to this question. Consequently in 2008 17% answer yes and 26% answer *partially*. This is a huge change from merely 4% and 17% respectively in 2006. Still, if any disaggregated data does exist, it is normally sex- and age-disaggregated data. Social class and ethnicity is without doubt more complicated to obtain.

Objective 5: Ensure the incorporation of the Millennium Development Goals and the Convention of the Rights of the Child in the development of the European Strategy

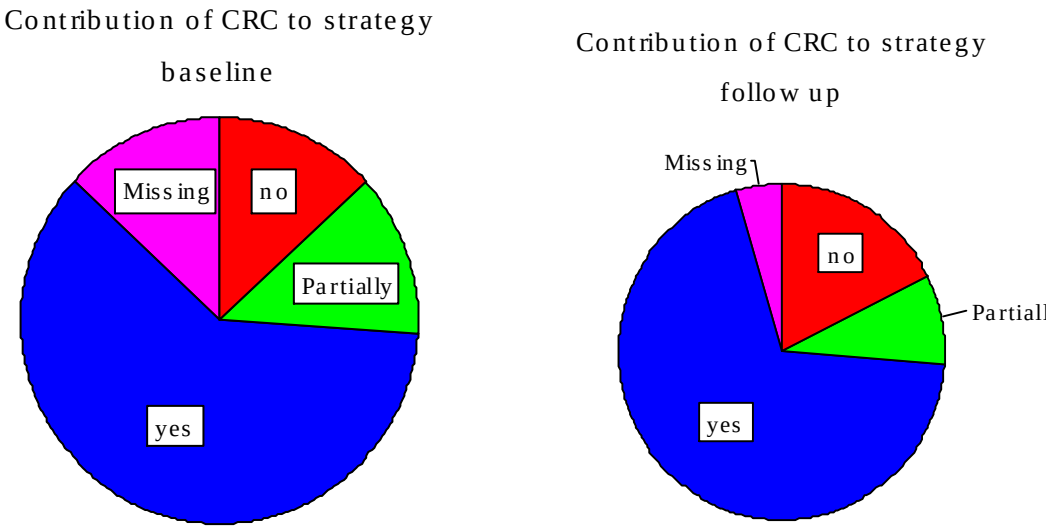
Indicator 5.1: Contribution of the strategy to the Millennium Development Goals



Thirty-five percent of the countries claim that the MDGs have contributed to a national strategy in some sense against only 22% in 2006. It will be interesting to see in what way the MDGs directly or indirectly are represented in the national strategies and how this contributes to the achievement of the MDGs. This item only provides us with the information that more than one third of the countries somehow are taking the MDGs into account in the review/development/implementation of a national strategy at this point in time. According to some of the comments, The MDGs have contributed to the review of previous solutions in the field of health care of children and youth, as well as to the assessment of the applicability of services for the achievement of the MDGs.

Many countries state that the main goals have been implemented into governmental documents and that they are also using or planning to use them in a draft national CAH strategy. Thus it seems that many programmes are reviewed and developed in the light of the MDGs. Uzbekistan has developed the action plan on how to achieve the MDG and monitor the results. In this connection reports from different sectors were reviewed in order to explore the current achievements and gaps to be filled within the next seven years.

Indicator 5.2: Contribution of the strategy to the Convention of the Rights of the Child

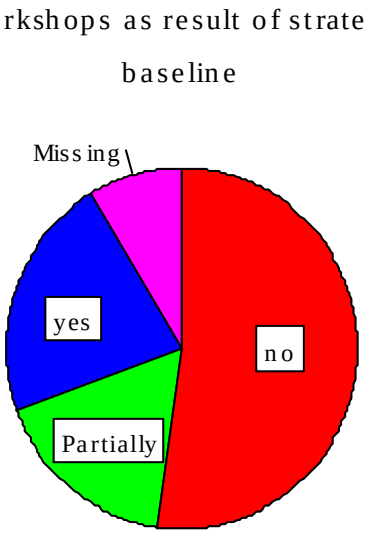


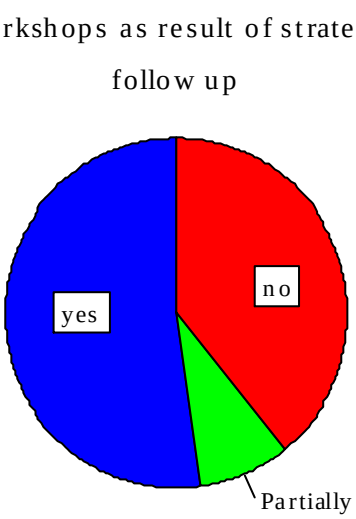
Plans for applying the Rights of the Child have been developed and adopted in several Member States. This is certainly also reflected in the fact that in 2008 70% state that the Convention of the Rights of the Child has somehow contributed to a national strategy (61% in 2006). It is worth noticing that only 35% answered yes to the same question regarding the contribution of the MDGs. This indicates that the MDGs are less integrated into the strategies than the Convention of the Rights of the Child, which will be discussed later in the report. Some countries state that they have a child ombudsman working with this convention.

In general the guiding principles of the CRC have been used as a framework for development of national strategies for children and youth in many countries. Thus the convention has underpinned a broad range of strategies. Especially in relation to equal access for health service, equal education, and equal access to sport, etc. Social protection, domestic violence issues been addressed as well.

Objective 6: Ensure existence of required staff, specialized skills and professional knowledge when developing and implementing the European Strategy

Indicator 6.1: Capacity building workshops





Logically there has been a big change over the two years in number of countries that have carried out capacity building workshops as a result of the European Strategy. In 2006 only 22% of the countries that completed the questionnaires had carried out such workshops. In 2008 52% of the countries have carried out the workshops. This means that more than half of the countries that completed the questionnaires have now gone through some kind of training in relation to the European Strategy. A correlation, between the variable measuring workshops and the one measuring WHO technical support, is naturally expected, because such workshops are an essential component of the technical support that is provided to the CAH activity countries. According to the comments to this item it can be concluded that several workshops on child and adolescent health have been organized at national, regional and local levels, but previous to the completion of the questionnaire few of them had been organized as a result of the European Strategy. Nevertheless some activities that are being planned or have already been carried out are linked to the European Strategy. Workshops in some countries are being carried out as a part of the regular work within child and adolescent health. These are obviously not being established as a result of the European Strategy, but nevertheless they could prove extremely valuable in the implementation of national strategies on child and adolescent health and development. This being mentioned, the workshops arranged as a result of the strategy have served mainly to give an overview of existing policies and strategies in the area of child and adolescent health, including identification of the gaps, and recommendation for future directions for a plan of activities involving all stakeholders.

Interrelation between different variables

Some actions seem to make other actions feasible or easier to carry out – e.g. national child and adolescent health data is needed in order to know which different population groups should be addressed explicitly in a national strategy. The following crosstabs illustrate how the presence or absence of one factor seems to be linked with the presence or absence of another factor. This gives us more detailed information regarding the work in the Member States and the different priorities that are made in parallel. The following analysis is based on the baseline data, due to

the fact that more countries participated. Therefore the correlations are more valid in baseline than in the follow up.

Review/development of national strategies based on the European Strategy

Table 3: Crosstab between initiated review/development of a national strategy for child and adolescent health and established multisectoral taskforce.

		Existence of a multisectoral taskforce/workgroup/committee on CAH and development			Total
		no	Partially	yes	
Initiated review/development/implementation strategies based on the European Strategy	no	4	0	4	8
	Partially	1	1	2	4
	yes	7	0	11	18
Total		12	1	17	30

Most of the countries that have already initiated a review or development of a national strategy for child and adolescent health have also established a multisectoral taskforce. Nevertheless seven countries out of the 18 countries that have initiated the development of the strategy do not have such a taskforce, although this is one of the guiding principles in the European Strategy.

National database of relevant child and adolescent health data

Table 4: Crosstabs between existence of a national child and adolescent health database and addressing different population groups and prenatal.

a		Addressing different population groups in the national strategy			Total
		no	Partially	yes	
Existence of a national database of relevant child and adolescent health data	no	1	0	1	2
	Partially	1	3	1	5
	yes	2	2	8	12
Total		4	5	10	19

b		Addressing prenatal children systematically and explicitly in a national strategy		Total
		no	Yes	
Existence of a national database of relevant child and adolescent health data	no	0	4	4
	Partially	2	4	6
	yes	0	13	13
Total		2	21	23

Countries that report that they have a database with relevant CAH data seem to manage the addressing of different age groups and different population groups in the strategy. This underlines the importance of evidence in the development of strategies.

Technical support from WHO

Table 5: Crosstabs between a) WHO Technical support and addressing population groups, and b) Addressing different population groups and Addressing different population groups as a result of the European Strategy.

a		**Addressing different population groups in the national strategy**			Total
		no	Partially	yes	
Direct technical support from WHO in the development of the national strategy	no	2	2	3	7
	Partially	1	1	2	4
	yes	1	2	5	8
Total		4	5	10	19
b		**Addressing different groups as a result of the European strategy**			Total
		no	Partially	yes	
Addressing different population groups in the national strategy	no	2	0	0	2
	Partially	2	2	0	4
	yes	3	1	6	10
Total		7	3	6	16

Most countries have addressed different age groups in a national strategy. In this regard it is important to note that a very large proportion of these countries have received technical support from WHO: Five out of eight countries who had received technical support also addressed different population groups in a national strategy. It furthermore seems that this has partly been done as a result of the strategy: 6 out of 10 countries addressed different population groups as a result of the European strategy, indicating that addressing different population groups in the national strategy has a lot to do with the implementation of the European Strategy.

Table 6: Crosstab between WHO technical support and contribution of the national strategies to the Millennium Development Goals and the Convention on the Rights of the Child.

a		Contribution of a national strategy to the MDGs			Total
		no	Partially	yes	
Direct technical support from WHO in the development of the national strategy	no	3	7	2	12
	Partially	2	2	3	7
	yes	1	2	5	8
Total		6	11	10	27

b		Contribution of a national strategy to the Convention on the Rights of the Child			
		no	Partially	yes	Total
Direct technical support from WHO in the development of the national strategy	no	3	4	7	14
	Partially	0	0	7	7
	yes	0	1	6	7
Total		3	5	20	28

It is important to note that the contribution of the national strategies to the MDGs is not as big as to the Convention on the Rights of the Child. It seems that touching upon the rights of the child is more independent of the technical support than touching upon the MDGs. There is thus as mentioned above a more frequent incorporation of the Rights of the Child compared to the Millennium Development Goals in the national strategies.

It is a part of the obligations under the convention of the Rights of the Child to make children visible in policy development processes throughout government by introducing child impact assessments. The convention was adopted in 1991 and has therefore existed much longer than the MDGs, which can be part of the reason why it is easier integrated in national strategies.

The relevance of integrating the MDGs cannot be doubted. Among the MDG 2005 World Summit Outcomes there were several points that are obvious contributors to the implementation of the strategy: Strong and unambiguous commitment by all governments, in donor and developing nations alike, to achieve the MDGs by 2015; Commitment by all developing countries to adopt national plans for achieving the MDG by 2006; Agreement to provide immediate support for quick impact initiatives to support anti-malaria efforts, education and healthcare; A scaling up of responses to HIV/AIDS, TB and Malaria, through prevention, care, treatment and support, and the mobilization of additional resources from national, bilateral, multilateral and private sources; Commitment to fight infectious diseases, including a commitment to ensure full implementation of the new International Health Regulations, and support for the Global Outbreak Alert and Response Network of the World Health Organization. A deeper understanding of the reasons behind the lacking integration of the MDGs in the national strategies is needed, if we should ensure a contribution of the strategies to the fulfilment of the governmental commitment regarding the MDGs.

Interesting Correlations

Capacity building workshops

Having carried out capacity building workshops is correlated with both addressing different age groups and addressing identified gaps in child and adolescent health (with correlation coefficients, r = 0.737 and 0.667 respectively). Furthermore it is also correlated with the involvement of youth in the development of the strategy (r = 0.691). This means that the effect of the workshops is already clearly detectable in the development/review of the strategy, when it comes to what is taken into account and mentioned in the strategy document. There is no significant correlation between other actions carried out as a result of the strategy, which is expected because of the early stage of the implementation process.

Addressing different groups in the population
Governmental budgetary allocations and/or reallocations of dedicated resources for CAH are closely correlated to the explicit and systematic mention of different age groups (r = 0.564) and to the mention of different age groups as a result of the strategy (r = 0.889). Moreover it is also correlated to the mention of identified gaps in the accessibility of child and adolescent health services as a result of the strategy (r = 0.746). Addressing these gaps as a result of the strategy is also correlated to addressing different age groups as a result of the strategy (r = 0.790) and addressing different population groups (such as socially disadvantaged, economic, ethnic and gender groups) as a result of the strategy (r = 0.812). This indicates that the mention of different age groups, population groups and different access to services are interrelated and that such inequities in health are mentioned in a national strategy to a larger extent if there have been dedicated more financial resources to child and adolescent health in the country.

Conclusion

Political commitment
More than half of the countries have initiated the development of a national strategy for child and adolescent health. At this point in time two out of five countries have received direct technical support from the WHO. The technical support appears to enhance the focus on different population groups that need explicit focus in the political planning.

In 65% of the countries a multisectoral taskforce existed in 2008 and almost two out of three countries that have initiated the implementation of the strategy have established such a taskforce. However it seems that most of the multisectoral taskforces were not established as a direct result of the European strategy.

Only 17% of the countries claim that there have been governmental budgetary allocations or reallocations of dedicated resources for CAH as a result of the European Strategy in 2008. Nevertheless this number has still doubled since 2006.

Guiding principles
More than one out of three countries replied that youth has been involved in the development/review/implementation of the strategy, but only few had done this as a result of the European Strategy. More than half of the countries claim that they have involved NGOs in the development of a national strategy. As expected there is a strong correlation between the involvement of youth and the involvement of NGOs.

The different age groups are being addressed by two out of three countries. Some age groups seemed to be addressed to a larger extent than others in 2006: prenatals being the age group that was mentioned most frequently whereas the age group of 5–9 year-olds was the least represented in the national strategies. However in 2008 all age groups seemed to be addressed almost to the same extent. In 2008 30% of the Member States answer that the mention of different age groups in a national strategy is a result of the European Strategy.

The most remarkable change over the two years is within equity. In 2006, 48% of the countries had detected substantial inequities in child and adolescent health, whereas in 2008 this number had increased to 74%. Meaning that 3/4 of the countries have detected these inequities. Correlations indicate that the mention of different age groups, population groups and different

access to services are interrelated and that such inequities in health are mentioned in a national strategy to a larger extent if there have been dedicated more financial resources to child and adolescent health in the country.

As opposed to involving NGOs, youth and mentioning the different age groups explicitly, the mention of different population groups in a national strategy – such as socially disadvantaged, ethnic, economic and gender groups – seems to happen as a result of the implementation of the European Strategy.

Provision of preventive and curative child health services
In 2006 almost half of the countries answered that no assessments were revealing gaps in the accessibility of child and adolescent health services have been carried out. This pattern seems to be changing because more and more assessments are being carried out in the field. In 2008 30% answered that assessments have revealed such gaps and practically all of these countries answered that the detected gaps in the accessibility of child and adolescent health care are now being addressed as a result of the European Strategy.

Standardized collection of data
Exactly half of the countries that completed the questionnaire claim that a national database of relevant child and adolescent health data exists and in 2008 almost all countries claim that such a database exists entirely or partially. However the strategy does not seem to have enhanced reviews of the national databases at the point in time when the questionnaires were completed.

Few of the countries claim that a national database contains exactly the same indicators as the CHILD database, but half of the countries claim that a database either entirely or partially contains such indicators. It is interesting that the countries that report that they have a database with relevant CAH data seem to manage the addressing of different age groups and different population groups in the strategy.

Finally still very little data exists in a disaggregated format. However the follow up survey has detected a substantial increase in the collection of disaggregated data as a direct result of the European Strategy.

Respecting international conventions and declarations
One out of three countries claim that the MDGs have contributed to a national strategy in some sense, while more than two out of three countries state that the Convention of the Rights of the Child has somehow contributed to a national strategy. This means that the MDGs are not integrated into the strategies to the same extent as the Convention of the Rights of the Child, indicating that the contribution of the national strategies to the MDGs does not seem as significant as the contribution to the Convention on the Rights of the Child. It is interesting that touching upon the Rights of the Child appears to be more independent of the technical support from WHO than touching upon the MDGs.

Capacity building
In 2006 one out of five countries had conducted capacity building workshops as a result of the European Strategy. At the point in time when the countries completed the follow up questionnaire more than half of the countries had conducted such workshops. The effect of the workshops is already clearly detectable in the development/review of national strategies in the sense that factors are taken into account and mentioned in a national strategy document. There is

no significant correlation between other actions carried out as a result of the strategy, which is expected because of the early stage of the implementation process.

Recommendations

Based on the conclusion of the analysis a list of recommendations has been developed. The list sums up the findings of the baseline survey and turns them into a series of tentative proposals that should be considered in the next steps of the evaluation. More information is needed on each one of these recommendations, before drawing any conclusions.

Recommendations based on the data analysis

- More emphasis on the establishment of a national multisectoral taskforce
- Provide assistance to countries regarding fundraising, since very few budgetary allocations for child and adolescent have been made in the countries
- Provide guidance regarding involvement of youth in the development of national strategies
- Provide guidance in regard to the step from needs assessment to accurate addressing of such needs in a national strategy and in action plans
- Increase the use of the information tool in the process
- Emphasize the importance of disaggregated data and existing data apart from health status data, e.g. introduce the CHILD database as a template and starting point
- Increase effort towards the integration of MDGs in the national strategies – provide guidance in regard to the overlap between the European Strategy and the MDGs and how the strategy is expected to contribute to the MDGs

Perspectives

The implementation process of health promotion programs or strategies can be viewed as an organizational change that occurs incrementally over time through several stages (appendix 3). Through the evaluation we found that most BCA countries have gone through implementation stage 1 and reached implementation stage 2 – that is exploration and program installation respectively. Since implementation of health promoting programmes is a dynamic process where it is very likely that these stages overlap and that the stakeholders at some point are bound to return to an earlier stage to refine and modify the process, it is difficult to determine exactly at what stage of the implementation process the given Member State was at the point in time the questionnaire was completed. It was interesting to see what the second round of the survey showed with regards to the advance in the implementation process. With this information it was possible to perceive the progress in the implementation of the European Strategy in terms of moving from the first stages to some of the later implementation stages, such as the actual implementation of the national strategies that have been developed in the meantime.

The questionnaire was developed with the aim of collecting very general, systematic information that should enable comparison between countries on some of the most universal factors in the implementation process. It does not allow us to understand the national implementation

processes in detail. Consequently it is crucial to supplement the survey with more in-depth, qualitative research, if we wish to improve and tailor the implementation approach further. During the autumn of 2007 the WHO Regional Office for Europe, together with the WHO Collaborating Centre for Health Promotion Capacity Building in Child and Adolescent Health (Florence, Italy), carried out case studies in several Member States in order to acquire a more detailed understanding of the country experiences of translating the European Strategy into a national strategy. The aim of these case studies was to inform about best practices and lessons learnt that can be used both in countries currently implementing the European Strategy and in countries that have not yet initiated the implementation phase. This also enabled the identification of the needed international contributions and support in the countries for the development of the national strategies. Furthermore the case studies highlighted the added value of the European strategy to the development of national strategies and policies by identifying an improvement in regard to:

- **Health systems** – more specifically a scaling up in regard to stewardship, resource creation, service delivery and financing
- **The four guiding principles of the European Strategy**
- Integration of **the Millennium Development Goals and The Convention on the Rights of the Child** in national strategies.

The information provided through the baseline survey was taken into account in the planning of the case studies and thus the case studies were built on the baseline survey making the two studies interdependent. The case study findings will, together with the results of this survey, be summarized in a report on the overall impact of the European Strategy, which will be prepared for September 2008, for the Regional Committee, and the lessons learnt will be circulated in the countries of the WHO European Region.

Appendix 1: The measurement framework

Objective	Indicator	Item
1. Increase the political commitment towards the development of national strategies	1.1. Initiated development and implementation of a National Strategy (Process)	1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?
	1.2. Provision of Technical Support from WHO (Input)	1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?
	1.3. Existence of a multisectoral workgroup (Input)	1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?
		1.3.1. If yes, has the multisectoral taskforce or working group been established as a result of the European Strategy for Child and Adolescent Health and Development?
		1.3.2. Which sectors are represented in the multisectoral taskforce/workgroup/committee
	1.4. Governmental budgetary allocations for child and adolescent health and development (Input)	1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?
	1.5. Participation of NGOs (Process)	1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?
		1.6. Which NGOs (name and area of work) have been directly involved in the review/development/ implementation of a national strategy for child and adolescent health and development?

Objective	**Indicator**	**Item**
2. Ensure the integration of the guiding principles of the European Strategy	2.1. Youth participation (Process)	2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?
		2.1.1. If yes: Has youth been involved in the review/development/ implementation of the Child and Adolescent Health Strategy as a result of the European Strategy of Child and Adolescent Health and Development?
		2.1.2. If yes: Which youth groups/organizations have participated in the review/development/ implementation of a national strategy for child and adolescent health and development?
	2.2. Explicit and systematically dealing with different age groups in strategy (Process)	2.2. Which different age groups have been systematically and explicitly addressed in a national strategy for child and adolescent health and development?
		2.2.1. Have these age groups been addressed in the national strategy as a result of the European Strategy of Child and Adolescent Health and Development?
	2.3. Assessing and addressing inequities between different population groups (Process)	2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups?
		2.3.1. Have these different population groups been addressed systematically in a national strategy for child and adolescent health and development?
		2.3.2. Which different groups of children are systematically and explicitly addressed in the strategy and related policies?

Objective	Indicator	Item
		2.3.3. Have these groups been addressed in the national strategy as a result of the European Strategy of Child and Adolescent Health and Development?
3. Improve the provision of preventive and curative child health services	3.1. Knowing the gaps in accessibility of child and adolescent health services (Output)	3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?
		3.1.1. If yes: In what kind of areas did the assessment reveal gaps in accessibility of current child and adolescent health services provided?
		3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?
4. Ensure that specific information systems are in place to support child and adolescent health and development	4.1. Existence of a national database of child and adolescent health data (Input)	4.1. Does a national database of relevant child and adolescent data exist?
		4.1.1. If yes: Has a current national database of relevant child and adolescent health data been reviewed/improved as a result of the European Strategy of Child and Adolescent Health and Development?
		4.1.2. Does a current national database contain the same indicators as the CHILD Database?
	4.2. Collection of disaggregated data (Process)	4.2. Has disaggregated data (SES, gender, age) related to child and adolescent health and development been collected as a result of the European Strategy?

Objective	Indicator	Item
5. Ensure the incorporation of the Millennium Development Goals and the Convention of the Rights of the Child in the development of the European Strategy.	5.1. Contribution of the strategy to the Millennium Development (Process)	5.1. Have the Millennium Development Goals contributed to the review/development/implementation of the strategy? In what way?
		5.1.1. If yes: In what way have the Millennium Development Goals contributed to the review/development/implementation of the strategy?
	5.2. Contribution of the strategy to the Convention of the Rights of the Child (Process)	5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy? In what way?
		5.2.1. If yes: In what way has the Convention of the Rights of the Child contributed to the review/development/ implementation of the strategy?
6. Ensure existence of required staff, specialized skills and professional knowledge when developing and implementing the European Strategy	6.1. Capacity building workshops (Process)	6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?
		6.1.1. If yes: What are the main outcomes of the workshops?

Appendix 2: Comments to questions

Comments	1. Albania
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	National Committee on Reproductive Health
2.3.1. Have these groups been addressed systematically in a national strategy for child and adolescent health and development?	Albania has a national strategy for children and adolescents
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Differences among children living in rural/suburban areas
4.1. Does a national database of relevant child and adolescent data exist?	A national database for adolescent health or neonatal health does not exist.
Comments	2. Armenia
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	Several meetings took place, materials reviewed
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	The taskforce exists, but its activities are not regular
1.3.1. If yes, has the multisectoral taskforce or working group been established as a result of the European Strategy for Child and Adolescent Health and Development?	This group had been working even at earlier stages – in the pilot period of the European Strategy Development
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	The time has been too short for the strategy to bring results. However, funding increase was initiated earlier, before introduction of the strategy.
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (e.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	Mainly at the level of nongovernmental organizations
2.1.1. Has youth been involved in the review/development/ implementation of the Child and Adolescent Health Strategy as a result of the European Strategy of Child and Adolescent Health and Development?	At the level of NGOs
2.3.1. Have these groups been addressed systematically in a national strategy for child and adolescent health and development?	Shortage of resources does not allow to meet all the needs
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	There is a problem of geographical access in rural districts

3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	New regional structures are being created
4.1. Does a national database of relevant child and adolescent data exist?	The database exists, but not as an integrated single structure.
6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?	Implemented activities are partly linked to the European Strategy
Comments	3. Azerbaijan
3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	The Quality Assurance Control Programme
Comments	4. Belarus
1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?	Information support, email correspondence, visits
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	The strategy is being developed in the framework of national programmes: “Children of Belarus”; “Young People of Belarus”; The National Programme of the Demographic Security etc.
4.1.2. Does a current national database contain the same indicators the CHILD database?	Much broader indicators are used
Comments	5. Bulgaria
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	1) Special financing from the National Health Insurance Fund for maternal and child health. 2) Several national programmes of child health improvement have been developed – prevention, prophylaxis etc., financed by the Ministry of Health of the republic of Bulgaria.
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (e.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	There has been established a Children’s Parliament
2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	Children are nor divided in groups in Bulgaria and they have equal rights.
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Because of difficult access to geographical regions
3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	Formation of mobile consulting offices in geographical regions with difficult access.
5.1. Have the Millennium Development Goals contributed to the review/development/implementation of the strategy?	There have been developed rules of achievement of Millennium Development Goals

5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	There has been developed and adopted an Integrated plan 2006–2010 for applying the Convention of the Rights of the Child by the Council of Ministers.
Comments	6. Croatia
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	Council for Children(established 01.10.1998)
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	Some governmental resources exist: Ombudsman for children (Ministry of justice); Family Counselling (Ministry of the Family, veteran affairs and Integrational Solidarity); County drug addiction prevention centres.
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (e.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	Youth have been involved in creating two strategic documents: National Programme Acting for Youth; National Plan for the Activities Aimed at Protecting the Rights and Interests of children for the periods 2006–2012.
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Croatian basic health insurance covers health insurance for all children and adolescents for preventive and curative care, hospitalization, for paediatric care, school health care and general practitioners.
4.1. Does a national database of relevant child and adolescent data exist?	Croatian Health Service Yearbook; Health Behaviour in School aged Children (HBSC); European Survey Project on Alcohol and other Drugs (ESPAD); Global Youth Tobacco Survey (GYTS); Data on Risk Behaviours, FAS, Health Behaviours.
5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	In the line with the Convention of Rights of the Child are: National Plan for the Activities Aimed at Protecting the Rights and Interests of Children for the Period 2006–2012; National Programme Acting for Youth
Comments	7. Cyprus
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	Workshops, meetings, materials
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	The allocated budgets are part of other applied programs and not as a result of the implementation of the European Strategy of Child and Adolescent Health and Development.
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (e.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	In limited areas through youth organizations
Comments	8. Czech Republic
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	1) The Commission for Child and Adolescent Health Care. 2) The working group for children's injury prevention. 3) The working group for CEHAPE. 4) The working group for obesity prevention.

1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	Preventive programs
4.1.1. Has a current national database of relevant child and adolescent health data been reviewed/improved as a result of the European Strategy of Child and Adolescent Health and Development?	Do not know
6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?	National action plan against obesity. National action plan of children's injury prevention.
Comments	9. Denmark
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	The Danish Strategy for Child and Adolescent Health is called "Better health for children and adolescent" and it was launched in November 2003. The strategy contains initiatives on how to support the effort that takes place every day within the individual families with children to ensure children and adolescents a healthy start. No new initiatives have been made based on the introduction of the new European Strategy in 2005.
3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	Since this introduction the Danish Health Board has published the following publications to support the work with child and adolescent health: Smoking, pregnancy and birth; Care for the pregnant and the families with little children that have problems with substance abuse; The home as an arena for prevention; Prevention of cot death; Health work at Schools; Methods and tools for the interventions against overweight; Prevention of overweight using the school as an arena; Increased emphasis on child environments and health; About hashish and adolescents; Children, adolescents and alcohol. Projects going on at the moment are: Review of the recommendations for the pregnancy care; The development of a catalogue for the municipalities in order to improve children's environment and health locally; Collaboration with the national association of the municipalities regarding the monitoring of child health; Case studies on hygiene of hands in day care. In other ministries the Danish Health board knows of the following projects: Training of health personnel in prevention of child abuse (Ministry of social affairs); Reducing the use of cosmetics or the like of pregnant and breastfeeding women.
4.1. Does a national database of relevant child and adolescent data exist?	Regional databases exist. The Danish Health Board is working on establishing a national database.
Comments	10. Estonia
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	We continued to finance the activities on the basis of the Strategy of the Rights of the Child 2004–2008 in 2006 and will also finance in 2007.
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	NGOs were involved to elaborate the Strategy of the Rights of the Child in 2003 and they will also participate in developing the National Strategy for Public Health 2008–2015.
2.1.1. Has youth been involved in the review/development/ implementation of the Child and Adolescent Health Strategy as a result of the European Strategy of Child and Adolescent Health and Development?	Estonian School Student Councils' Union was involved already in 2003.
2.2.1. Have these age groups been addressed in the national strategy as a result of the European Strategy of child and Adolescent Health and Development?	The activities for these age groups have been based on the concept of Health Promoting Schools and Kindergartens.

2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	First data from the HBSC Survey 2006 revealed that self-reported health estimate is lower among the children from families with lower income. There is no regular health statistics available in Estonia to reveal the inequities among children from different social groups.
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	There are big differences in the use of the health services e.g. young counselling services for reproductive health are mainly used by female clients (in 2004 96% female, 4% male).
4.1. Does a national database of relevant child and adolescent data exist?	Routinely collected health statistics (mortality, morbidity, immunizations, use of ambulatory and hospital care, data from school health services, newborn screening, and youth counselling for reproductive health).
4.1.2. Does a current national database contain the same indicators the CHILD database?	Data on socioeconomic conditions are not routinely collected.
Comments	11. Finland
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	However we have some other initiatives. We plan to establish an advisory body for children's and youth's health. This body would prepare a strategy.
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	See 1.1. This body is planned to be multisectoral.
2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	We know from the statistics that there are some inequities among different population groups (e.g. economic groups)
4.1. Does a national database of relevant child and adolescent data exist?	We have plans to develop national databases within the national institute of health and … (National research centre)
5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	However, we have a child' ombudsman and related advisory board.
Comments	12. Georgia
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	The policy of the Ministry of Health of Georgia is the main strategic document, which includes Mother and Child health care as one of the priority directions.
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	Committee has not been established yet, but it is planned to set up a workgroup. Several funds and NGOs (UNICEF, UNFPA, USAID) are active in various fields: child development, protection of rights, education, safe motherhood, reproductive health.
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	Reflected in state programmes
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	Various local NGOs, mostly professional associations

2.1.1. Has youth been involved in the review/development/ implementation of the Child and Adolescent Health Strategy as a result of the European Strategy of Child and Adolescent Health and Development?	Young people participate in educational programmes “Peer Education” through local NGOs and international organizations
2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	Evaluation and comparative analysis of health status in various groups has not been carried out
2.3.1. Have these groups been addressed systematically in a national strategy for child and adolescent health and development?	In the framework of the state programme
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Has not been evaluated
4.1. Does a national database of relevant child and adolescent data exist?	National Health Statistics
5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	Goals of the Convention on the Rights of the Child are main objectives of national and various above-mentioned programmes
Comments	13. Greece
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	The country has not initiated a review etc. of child and adolescent health strategies based on the European Strategy. However several workshops, meetings and conferences are organized by different state organizations, NGOs, University Departments, Research Institutions and scientific societies which provide information and present the development of policies, new research findings and approaches related to children and adolescent health and development.
1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?	Neither the Institute of Child Health nor any other organization, from the organizations we have contacted, has received any technical support from WHO in the development of the national strategy.
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	There is not any formal multisectoral taskforce, workgroups or committee on child and adolescent health and development. However the Institute of Child Health consists of an interdisciplinary group of scientists and researchers, paediatricians, child psychiatrists, psychologists, anthropologists, sociologists, geneticists, biochemists, health promoters, statisticians and others who work in an interdisciplinary way regarding the child and adolescent. The Institute has developed links and collaborations with the educational and the health sectors, governmental and non – governmental organizations, collaborating and communicating in research, developments, proposals for policies etc. In a way an informal task force is on the way. Informal cooperations are in process, not in the form of a specific working taskforce group with unified aims. With this meaning the Institute of Child Health which is an interdisciplinary research and health promoting organization sponsored by the Ministry of Health, represents the health sector and cooperates on issues related to child and adolescent health and development with other health and educational organizations like the Paediatric Department of the Athens University, the “AGHIA SOPHIA” Children’s Hospital, the Adolescent Department of Athens University, the Psychiatric Department of Athens University, the National School of Public Health, the Departments of the Ministry of Education related to School Health Promotion, the organization related to Children’s Rights, the judicial Departments representing the legal status of young people and justice, organizations related to pollution and Ministerial Departments related to Environment, to Social Welfare, to Social Order, organizations related to labour policies, to migration, to media, to consumer safety and other.

1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	As far as we know there have not been specific allocations for the European Strategy of Child and Adolescent Health and Development. However there have been allocations or reallocations related to child and adolescent health and care. Specifically in relation to drug prevention, health education and for other issues
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	There does not exist a national strategy directly involved in the review of child and adolescent health. However several NGOs and other non state, scientific organizations are involved in programmes which have a holistic approach regarding the development of child and adolescent health. This is new for the country as the child and adolescent development is approached in a holistic way including the broader environment, life style, emotional, physical and social health state and is not cared in a strictly traditional medical way.
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	A specific Strategy for Child and Adolescent is not explicitly working. However the Ministry of Education is creating 58 counselling centres for young people and their families; OKANA, (organization against drugs) sponsored by the state has created about 60 and is about to create more prevention centres assisting young people and their families in the area of prevention and providing information to schools and educators. The Secretariat of Youth organizes out door activities for young people aiming to develop social health, most Municipalities-Local Authorities have youth centres providing centres for young people where they can develop different activities during leisure time, sport associations provide opportunities for physical activities to young people, in the University students are represented by elected organizations working for issues of their interest, schools have pupils' councils which however have very limited power and involvement in planning. Generally there is a lot of activity related to or involving young people directly but there is no coordination and they do not work for well planned unified aims.
2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	There are no national assessments as such. However older and more recent research studies focusing on population cohorts have shown inequities among different population groups.
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	There may not exist national assessments we know that there exist gaps in the accessibility of child and adolescent health services especially to services related with mental health issues.
3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	There have been taken initiatives addressing the problem of accessibility. Mobile health units have been organized by state and non governmental organizations.
5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	A meeting is organized on 2/10/06 for the "European and National Strategy for Children's Rights". The responsible office in Greece for Children's Rights is active in the educational and other sectors promoting the Convention.
6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?	Several workshops are organized on child and adolescent health at national, regional and local level. But until the present day, none is organized as the result of the European Strategy
Comments	14. Hungary
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	Own national Infant and Child Health Program has been made, named: Children are common treasure.

1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?	Indirect personal connection with the WHO Country Office for Hungary
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	Committee for helping the implementation of the national program – multisectoral representation
4.1.2. Does a current national database contain the same indicators the CHILD database?	Target is to harmonize them with the CHILD Database
Comments	15. Ireland
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	Workshop held
1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?	Support has been offered but as yet Ireland has not taken up this offer
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	A number of structures are currently working to address issues of child and adolescent health. 1) Within the Health Services an expert advisory group on children is operating. 2) At the cross-sectoral level a national children's statutory services group is in operation, this includes justice, health, education, community and rural affairs.
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	Under the auspices of the National Children's Strategy a youth forum is in operation which is available on an on-going basis for consultation with young people.
2.3.1. Have these groups been addressed systematically in a national strategy for child and adolescent health and development?	National Anti Poverty Strategy and many related disadvantage focused strategies
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Indicators highlight some gaps and unevenness of service
3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	Review of Childcare and Health Services underway
4.1. Does a national database of relevant child and adolescent data exist?	Extensive "State of Nations Children Report" recently completed.
5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	A comprehensive National Children's Strategy is in place
Comments	16. Israel
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	There has been a national Council for Paediatrics and Child Health (NCPCH) which deals with the strategic approach, development, implementation and periodic review of policy and clinical issues.

1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?	Not as a general approach, but several Israeli paediatricians are engaged with WHO working groups on specific topics
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	The Israeli NCPCH acts as an overarching multisectoral body for this aim.
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	Youth Parliament and others
2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	For example: Infant mortality rates among minorities.
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	There has been a national health security plan since 1995 with 100% coverage.
4.1.1. Has a current national database of relevant child and adolescent health data been reviewed/improved as a result of the European Strategy of Child and Adolescent Health and Development?	not yet..
Comments	17. Italy
1.3.1. If yes, has the multisectoral taskforce or working group been established as a result of the European Strategy for Child and Adolescent Health and Development?	National Health Plan and National Norms
2.2.1. Have these age groups been addressed in the national strategy as a result of the European Strategy of child and Adolescent Health and Development?	National Health Plan and National Norms
5.1. Have the Millennium Development Goals contributed to the review/development/implementation of the strategy?	National Health Plan and National Norms
5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	National Health Plan and National Norms
Comments	18. Kyrgyzstan
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	Order No 3 is issued on setting up a workgroup for the strategy development. A meeting of the Workgroup took place, with participation of heads of MOH departments and the MOH state-secretary. The meeting discussed the current situation, problems, etc. in relation with children in KGZ.
1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?	Telephone consultations, emails, invitation to Trieste, Italy, to participate in discussions
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	However, such group will be established very soon, as decided at the MOH meeting that discussed the National strategy.

1.3.1. If yes, has the multisectoral taskforce or working group been established as a result of the European Strategy for Child and Adolescent Health and Development?	Workgroup has been set up by MOH and the National centre of paediatrics and paediatric surgery, it also includes representatives of the Mandatory health insurance fund. See also 1.3
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	Not yet
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	Not yet
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	Not yet, see 1.3
2.2.1. Have these age groups been addressed in the national strategy as a result of the European Strategy of child and Adolescent Health and Development?	This will be taken into consideration in the National Strategy that is under development
2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	High mortality among newborns with birth weight of 1000 g and more. Increase of incidence of mental and behavioural disorders, iron deficiencies; increased number of disabled among children below 14.
2.3.1. Have these groups been addressed systematically in a national strategy for child and adolescent health and development?	In the framework of “Manas Taalimi” programme, but will also be addressed in the National strategy
2.3.3. Have these groups been addressed in the national strategy as a result of the European Strategy of Child and Adolescent Health and Development?	Partially, in the framework of “Manas Taalimi” programme
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	There is a lack of specialists within particular areas
3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	Will be addressed in the future National strategy
4.1. Does a national database of relevant child and adolescent data exist?	Republican centre of health statistics
4.1.1. Has a current national database of relevant child and adolescent health data been reviewed/improved as a result of the European Strategy of Child and Adolescent Health and Development?	Yes, within IMCI
5.1. Have the Millennium Development Goals contributed to the review/development/implementation of the strategy?	One of the goals is addressed in the national programme “Manas Taalimi”. Will also be addressed in the National strategy
5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	See 5.1

6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?	Being planned
Comments	19. Latvia
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	In the Republic of Latvia there has not been developed a strategy based on the European Strategy, because activities mentioned in the European Strategy are included in national policy planning documents, for example, Strategy of Public Health, Strategy of mother and Child Health, The Program for Limiting the Spread of HIV/AIDS in Latvia 2003–2007.
1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?	Ministry of Health of the Republic of Latvia has received materials from WHO consultants and took part in the discussions.
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	At the Ministry of Health of the Republic of Latvia there are established several multisectoral workgroups, for example, to develop the unitary medical form for family doctors and paediatricians; to develop the new solution variant for the draft of conception “Youth Friendly Health Services”, Coordination Committee on Limiting Spread of Sexually Transmitted Diseases and HIV infection, The Nutrition Council and others.
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	In policy planning of health care for child and adolescent several NGOs take part.
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	At the time of development of policy planning documents in Latvia, youth participants can express their opinion and take part in the discussions about particular draft documents.
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Law on Protection of Children’s Rights and Law on Medical Treatment state that all children under 18 years receive state guaranteed health care services without charge. According to the Rules of Cabinet of Ministers of the Republic of Latvia No. 1036, “Procedures for the Organization and Financing of Health Care”, children under 18 years are exempted from patient co-payment receiving health care services.
4.1. Does a national database of relevant child and adolescent data exist?	The health statistics and Medical Technologies State Agency of the Republic of Latvia has a State’s Registrer of the Newborns. The statistical data on child and adolescent health are collected reposing on reports of physicians.
4.1.2. Does a current national database contain the same indicators the CHILD database?	Data on child and adolescent health are collected accordingly to the database “Health for All” of WHO
Comments	20. Lithuania
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	Standing work group on child health protection exist from 2003, created by State Public health Care Service. Joint Board on Child Well-being was created in 2005.
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	Funds from: Mother and Child State Programme (2004–2006), National Public Health Strategy 2006–2013.
2.2.1. Have these age groups been addressed in the national strategy as a result of the European Strategy of child and Adolescent Health and Development?	This programme was prepared in 2003

2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	National Health Board annual report 2005 has shown some inequalities in child mental health status in urban and rural areas.
2.3.1. Have these groups been addressed systematically in a national strategy for child and adolescent health and development?	Different child age groups will be represented in State family Health Program and State Child Health Promotion Program. These programs will be drafted in 2007–2008.
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Youth Friendly Services (including primary health care, health education and social care) assessment in 6 municipalities, 2004, implementing financed by UNDP, UNICEF and Ministry of Health Project "Youth Friendly Services in Lithuania".
3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	Two municipalities from six (red: regions) have prepared strategies on children and youth health and development following results of assessment mentioned above at the beginning of 2005.
4.1. Does a national database of relevant child and adolescent data exist?	The Medical Birth Register started functioning in Lithuanian January 1, 1993. Nine annual publications of Medical Birth Register were issued in 1995, 1996, 1997, 1998, 1999, 2000, 2001 and 2003. Register database is official statistics. Website address of the data above-mentioned database of years 2001, 2002, 2003 and 2004 is: www.lsic.lt. The child data presentation system is available to compare and display in user friendly graphical forms, child demographical, morbidity, mortality, disablement data that are available by geographical or administrative data.
Comments	21. Malta
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	Malta is not currently participating in the strategy; however the Health Promotion Department is very active in the area of the Child and Adolescent Health Promotion through various programmes initiated by WHO.
2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	Evaluations and assessments have not been carried out
4.1. Does a national database of relevant child and adolescent data exist?	The Health Promotion Department carries out the WHO Health Behaviour of School-aged Children Study every four years. Two studies have been carried out to date. The only data available for child and adolescent health is the data from these studies.
Comments	22. Montenegro
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	National Committee for the National Plan of Action for Children
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	The government would allocate budgetary resources for adopted strategic documents in the nearest future, bearing in mind that these documents are recently adopted.
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	In development of National Action Plan for youth and national action plan for children. Several NGOs have been involved in drafting the action plan.

2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	Mostly through NGOs
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Differences are identified in different regions of the country, among Roma population and refugees and displaced.
4.1.1. Has a current national database of relevant child and adolescent health data been reviewed/improved as a result of the European Strategy of Child and Adolescent Health and Development?	Database was established before adoption of European Strategy for Child and Adolescent Health and Development
Comments	23. Netherlands
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	The current strategy was implemented in 2003. A review of the Child and Adolescent Health Strategy was executed in 2006 (reported November 2006, only in Dutch).
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	The juvenile health centre at the National Institute for Public Health and the Environment sets up specific work groups for actual topics regarding child and adolescent health.
1.3.1. If yes, has the multisectoral taskforce or working group been established as a result of the European Strategy for Child and Adolescent Health and Development?	The sectors depend on the subject that is in discussion
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	Policy on child and adolescent health of the Netherlands covers the issues mentioned in the strategy
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	The programme is developed in cooperation with umbrella organizations mentioned by 1–3. For specific parts of the programme many scientific or professional organizations are involved. There is a regular contact between the Ministry of Health and NGOs about these issues though.
2.2.1. Have these age groups been addressed in the national strategy as a result of the European Strategy of child and Adolescent Health and Development?	The programme contains many activities which are executed on specific moments of development or are targeted to specific (age)groups
2.3.1. Have these groups been addressed systematically in a national strategy for child and adolescent health and development?	They are addressed in specific policy programmes but not in an overall juvenile health programme.
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	A recent evaluation of the juvenile health programme (2006) showed that no such gap exists.
4.1. Does a national database of relevant child and adolescent data exist?	At this moment the database contains information collected by interviews. In near future the complete dataset collected in the juvenile health programme can be presented on a level which gives an accurate and actual picture of child and juvenile health.
4.1.2. Does a current national database contain the same indicators the CHILD database?	I did not receive the report and cannot make the comparison.

5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	The Convention is also a basis for the national child and adolescent health strategy.
6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?	Such workshops are organized by Juvenile Health Centre at the National Institute for Public Health and the Environment.
Comments	24. Norway
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	There are many groups working in this area
1.3.1. If yes, has the multisectoral taskforce or working group been established as a result of the European Strategy for Child and Adolescent Health and Development?	We have a working group on the CEHAPE that is multisectoral, there are working groups on developing parent counselling programme.
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	Not considered necessary
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	Adolescents are involved in Youth friendly services
3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	In Norway the task on children's and adolescent's health services is continued.
6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?	It is part of our regular work
Comments	25. Poland
4.1. Does a national database of relevant child and adolescent data exist?	Data regarding health of children and young people are gathered in several institutions, for example in the Central Statistical Office, The National Institute of Hygiene, the Chief Sanitary Inspectorate, the Institute of Mother and Child in Warsaw and the National Centre for Health Information Systems.
5.1. Have the Millennium Development Goals contributed to the review/development/implementation of the strategy?	The Millennium Development Goals have contributed to the review of previous solutions in the field of health care of children and youth, as well as to the assessment of their applicability for the achievement of the Millennium Development Goals.
Comments	26. Republic of Moldova
4.1. Does a national database of relevant child and adolescent data exist?	There is no data on social and ethnic groups
4.1.1. Has a current national database of relevant child and adolescent health data been reviewed/improved as a result of the European Strategy of Child and Adolescent Health and Development?	Relevant structures were approached to improve the national database.
4.1.2. Does a current national database contain the same indicators the CHILD database?	Indicators are not yet the same
4.2. Has disaggregated data (SES, gender, age) related to child and adolescent health and development been collected as a result of the European Strategy?	Not yet

6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?	There was a joint meeting of the Ministry staff and external chief specialists.
Comments	28. Serbia
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	Serbia already adopted above strategies: 1) Neonatal protection; 2) National Strategy for Adolescent Health; 3) National Strategy for HIV/AIDS; 4) Supporting of the breastfeeding. Implementation of the strategies will be through the established National Commissions.
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	1) Telephone counselling for "healthy babies" – 24. hours a day; 2) Restructuring of delivery rooms around hospitals; 3) Restructuring of Institute for neonatology; 4) National Strategy for HIV/AIDS (adopted from the Government); 5) National Strategy for adolescent health (adopted from the Government).
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	1) Serbian Public Health Association; 2) JAZAS / for HIV/AIDS; 3) Promotion of breastfeeding
2.2.1. Have these age groups been addressed in the national strategy as a result of the European Strategy of child and Adolescent Health and Development?	Baby Friendly Hospital initiative
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Luck of data base information's for different areas
5.1. Have the Millennium Development Goals contributed to the review/development/implementation of the strategy?	They are integrated in the strategies
5.2. Has the Convention of the Rights of the Child contributed to the review/development/implementation of a national strategy?	It is integrated part of the strategies.
Comments	29. Slovakia
2.2.1. Have these age groups been addressed in the national strategy as a result of the European Strategy of child and Adolescent Health and Development?	e.g. the National Strategy for Prenatal and Neonatal Care
4.1. Does a national database of relevant child and adolescent data exist?	The National Centre of the Health Information collects basic data about morbidity and mortality in childhood.
Comments	30. Spain
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	There exists a strategic national plan for child and adolescent health and development
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	Within the area of prevention of maltreatments; prevention of deafness within the newborns; prevention of iodide deficit during pregnancy and promotion of breastfeeding; prevention of unwanted pregnancy among adolescents.
1.3.1. If yes, has the multisectoral taskforce or working group been established as a result of the European Strategy for Child and Adolescent Health and Development?	Furthermore they are within the national policy of childhood and youth.

2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	The immigrant population
4.1. Does a national database of relevant child and adolescent data exist?	Statistics regarding voluntary interruption of pregnancy where data regarding young mothers' abortion is collected at a national level.
4.1.1. Has a current national database of relevant child and adolescent health data been reviewed/improved as a result of the European Strategy of Child and Adolescent Health and Development?	It has not been necessary to incorporate new data in the present register, using the data that WHO requests regularly from us.
4.2. Has disaggregated data (SES, gender, age) related to child and adolescent health and development been collected as a result of the European Strategy?	The data of voluntary interruption of pregnancy contains individualised data which means that it is nor necessary to disaggregate it.
Comments	31. The Former Yugoslav Republic of Macedonia
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	Assessment of health, social and education services for young people and adolescents was conducted in 2005 and national working group was established for the purpose of this assessment.
1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	All activities so far were conducted with the technical support from UNICEF and GF-HIV/AIDS
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	Working group for development of a national strategy for adolescent and young people's health and development is established and a … of NGO is included.
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	They are included in the National work groups for development of the strategy. Final version will be subject of focus discussion with different NGOs working in the field of health promotion.
4.1. Does a national database of relevant child and adolescent data exist?	Very weak data collection and data are nor disaggregated
6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?	Within the agreement with UNICEF and GF funded program for HIV/AIDS prevention initial workshops for Orientation Programme, Facilitators Guide for health and social workers on adolescent health were conducted and will be continued.
Comments	34. Ukraine
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	The work has been carried out with use of Information tool and Assessment tool. A workshop was organized with the technical assistance from WHO European Office, where results of the situation analysis of the regulatory and legislative basis and of the child health situation in Ukraine were discussed
1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?	On the initial stages of the strategy elaboration, several consultations and meetings with WHO staff took place
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	There is a department on maternal and child health care in the Ministry of health
1.3.1. If yes, has the multisectoral taskforce or working group been established as a result of the European Strategy for Child and Adolescent Health and Development?	A workgroup on the Strategy development will be created

1.4. Have there been any governmental budgetary allocations and/or reallocations of dedicated resources for child and adolescent health and development as a result of the implementation of the European Strategy of Child and Adolescent Health and Development?	It can be expected, that after the Strategy is adopted, budget funds will be allocated for this purpose
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	The Ministry of health plans to involve NGOs in the process of the strategy development
2.1. Has youth been involved in the review/development/implementation of the Child and Adolescent Health Strategy (E.g. through hearings, policy planning, design and running of youth-friendly services etc.)?	Participated in the workshop, that discussed results of the situation analysis in Ukraine.
2.1.1. Has youth been involved in the review/development/ implementation of the Child and Adolescent Health Strategy as a result of the European Strategy of Child and Adolescent Health and Development?	Representatives of youth organizations attended the workshop 1–2 November 2006.
2.3. Have assessments revealed substantial inequities in child and adolescent health among different population groups (for examples of different population groups see question 2.3.2.)?	Health of children in rural areas is worse vs. urban children.
2.3.1. Have these groups been addressed systematically in a national strategy for child and adolescent health and development?	These aspects will be taken into account in the process of the strategy development.
2.3.3. Have these groups been addressed in the national strategy as a result of the European Strategy of Child and Adolescent Health and Development?	Needs of children in all age groups will be addressed. Gender groups – No
3.1. Have assessments revealed substantial gaps in the accessibility of current child and adolescent health services provided – e.g. differences between rural, suburban and specific urban areas?	Children living in rural areas have poorer access to health care services than urban children.
3.2. Have initiatives or actions been established to address the identified gaps in current child and adolescent health services provided as a result of the Strategy for Child and Adolescent Health and Development?	These aspects will be taken into account in the process of the strategy development.
4.1. Does a national database of relevant child and adolescent data exist?	Statistical information on child and adolescent health is available
4.1.1. Has a current national database of relevant child and adolescent health data been reviewed/improved as a result of the European Strategy of Child and Adolescent Health and Development?	Certain statistical data may be revised in the process of the strategy development
4.1.2. Does a current national database contain the same indicators the CHILD database?	Main health indicators (child morbidity and mortality disaggregated by sex and age)
4.2. Has disaggregated data (SES, gender, age) related to child and adolescent health and development been collected as a result of the European Strategy?	A database with sex- and age-disaggregated information already exists
5.1. Have the Millennium Development Goals contributed to the review/development/implementation of the strategy?	By all means
6.1. Have capacity building workshops on national child and adolescent health strategies been carried out as a result of the European strategy?	A thorough analysis and evaluation of the existing situation in the Ukrainian legislative base, and in the area of child and adolescent health.

Comments	35. Uzbekistan
1.1. Has the country initiated a review/development/implementation (such as workshops, meetings, materials, review of current government policies etc.) of child and adolescent health strategies based on the European Strategy?	The review of the state programmes has started
1.2. Has the country received direct technical support (visits, telephone calls, email correspondence etc.) from WHO in the development of the national strategy?	We expect that a workshop will be organized together with WHO and technical assistance in drafting national strategy will then be provided.
1.3. Does a multisectoral taskforce/workgroup/committee exist on child and adolescent health and development?	The Government Commission on protection of the mother and the healthy generation is created under the Cabinet of Ministers
1.3.1. If yes, has the multisectoral taskforce or working group been established as a result of the European Strategy for Child and Adolescent Health and Development?	This commission was established in 2002 for the purpose of monitoring the state Programme on mother and child protection.
1.5. Have NGOs been directly involved in the review/development/implementation of a national strategy for child and adolescent health and development?	Youth movement “Kamolot” and representatives of the Children’s Parliament will be involved in the review process
5.1. Have the Millennium Development Goals contributed to the review/development/implementation of the strategy?	MDG are addressed in the State programme No 242 (5.07.2002) on mother and child care.

Appendix 3: The Implementation Stages of health promotion programmes

Stage	Stages of implementation	Description of stage
1	Exploration	The purpose of exploration is to assess the potential match between community needs, evidence-based practice and program needs, and community resources and to make a decision to proceed (or not). Understanding the enabling and limiting aspects of the contexts in which interventions can occur seem to be important during the exploration process. All stakeholders meet and exchange information to • identify the needs • acquire information via interactions • assess the fit between the intervention and the needs • provide information and support to other partners At the end of the exploration stage, a decision is made to proceed with implementation of an evidence-based program.
2	Program Installation	Structural supports necessary to initiate the program are put in place. These include ensuring the availability of • funding streams, • human resource strategies, • policy development • creating referral mechanisms, • reporting frameworks and outcome expectations.
3	Initial implementation	Implementation requires changes in the overall practice environment. That is - the practitioner in the context of personal, - administrative, educational, economic, and community factors that are themselves influenced by external factors (new info, societal norms, economic recession, media). Changes in skill levels, organizational capacity, organizational culture, and so on require education, practice, and time to mature and confidence in the decision to adopt the program.
4	Full operation	Full implementation of an innovation can occur once the new learning becomes integrated into practitioner, organizational, and community practices, policies, and procedures. Over time, the innovation becomes “accepted practice” and a new operationalization of “treatment as usual” takes its place in the community (Faggin, 1985).
5	Innovation	Each attempted implementation of evidence-based practices and programs presents an opportunity to learn more about the program itself and the conditions under which it can be used with fidelity and good effect. New staff members working under different conditions present implementation challenges, but they also present opportunities to refine and expand the implementation practices and programs.
6	Sustainability	The goal during this stage is the long-term survival and continued effectiveness of the implementation site in the context of a changing world. Skilled practitioners and other well trained staff leave and must be replaced with other skilled practitioners and well-trained staff. Leaders, funding streams, and program requirements change. New social problems arise; partners come and go. External systems change with some frequency and political alliances are only temporary. Through it all the implementation leaders and staff must be aware of the shifting ecology of influence factors and adjust without losing the functional components of the evidence-based program or dying due to a lack of essential financial and political support.

Source: http://nirn.fmhi.usf.edu/implementation/06/06_stagesimple.cfm