



European strategy for child and adolescent health and development

From resolution to action

2005-2008

ABSTRACT

Children are our investment in tomorrow's society. Their health and the way in which we nurture them through adolescence into adulthood will affect the prosperity and stability of countries in the European Region over the coming decades.

Keywords

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The European Strategy – where has it come from?

Introduction

In general, children in the European Region benefit from better health and development opportunities than ever before. Infant and child mortality rates in some European countries are among the lowest in the world.

There are, however, striking inequalities across the 53 countries in the WHO European Region in health status and in access to health services, with over ten-fold differences in infant and child mortality rates. Inequalities are also growing within countries, with women, children and disadvantaged and marginalized groups being particularly at risk.

There are numerous threats to the health and well-being of children and young people in the Region, such as obesity, sexually transmitted diseases and psychosocial and mental health disorders, are adding to the existing threats of malnutrition, perinatal problems and infectious diseases. Concerns have been raised about the current and future threats to health and well-being posed by polluted environments and by the adoption of health-compromising behaviours and lifestyles among young people.

It is against this background that the *WHO European strategy for child and adolescent health and development* was created, focusing on the seven priority areas for action of WHO's *Strategic directions for improving the health and development of children and adolescents*, which were endorsed unanimously by Member States at the Fifty-sixth World Health Assembly in May 2003:

- mothers and neonates
- nutrition
- communicable diseases
- injuries and violence
- physical environment
- adolescent health
- psychosocial development and mental health.

The *WHO European strategy for child and adolescent health and development*, which was adopted by the WHO Regional Committee in September 2005 following over two years of development work (Annex 1), reflects the moral and legal obligation to protect and promote the rights of children and young people. It also marks the understanding that investment in the early stages of life has lifelong impact, affecting economic development and sustainability and the establishment of a healthier society in future years.

Strategy implementation in Member States is being linked to the health systems approach. Health systems are defined as the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health.

The health system is seen as: providing stewardship for child and adolescent health through political commitment and effective regulation and accountability; creating resources for investment and training; developing service-delivery mechanisms that are both person- and population-based; and providing financing to ensure a robust base for pre-paid services. This creates the conditions for the achievement of strategic goals of the system, which are to enable satisfactory levels of health and health equity among the population, ensure appropriate responsiveness to people's health needs, and create fair distribution of the burden of financing.

The health system model is considered particularly useful as it lays the foundations for intersectoral responses to systemic problems and barriers. It can be used to outline long-term high-level outcomes, intermediate outcomes and immediate actions within a comprehensive model that enables all institutions and actors to identify and understand their role. An intersectoral, strategic-level approach which focuses on health outcomes is central to implementation of the *WHO European strategy for child and adolescent health and development*.

The Strategy – what it is, and what it is not

It is important to understand both what the Strategy *is*, and what it *is not*.

The Strategy *is not*:

- a “one-size-fits-all” solution for all countries in the Region
- prescriptive
- a set of pre-decided Regional targets.

Rather, the Strategy *is*:

- a framework to allow countries and Regions to develop their own policies and programmes;
- a range of policy options based on best evidence;
- an external impetus to encourage countries and Regions to set their own targets and indicators; and
- a driver for action.

The Strategy is designed to offer Member States a unique opportunity to make a difference to the health and well-being of children and adolescents in their countries and regions. It recognizes that circumstances vary between countries and is designed to be used flexibly to meet individual country needs.

Development of the Strategy was informed by four guiding principles:

- **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 of health should be adopted when devising policies and plans to improve the health of children and adolescents; and

- **participation:** the public and young people themselves should be involved in the planning, delivery and monitoring of policies and services.

The Strategy is based on a wide range of data about children’s and adolescents’ health behaviours in Europe that reflect lifestyle, behavioural, cultural and socioeconomic factors. It sets out three objectives:

- to provide a framework for evidence-based review and improvement of national policies and programmes for child and adolescent health and development from a life-course perspective;
- to promote intersectoral action to address the main health issues regarding child and adolescent health – collaboration outside the health sector is seen as essential, with education and school settings identified as particularly important; and
- to identify the role of the health sector in the development and coordination of policies and service delivery to meet the needs of children and adolescents.

The Strategy can help policy-makers by:

- offering practical help in formulating national strategies;
- providing evidence-based answers to challenges;
- enabling decision-makers to build necessary capacity;
- focusing beyond the health sector; and
- identifying the most important factors in developing a national strategy in the accompanying Toolkit.

The Toolkit

A four-part Toolkit accompanies the Strategy, providing resources to enable Member States to determine any gaps in their plans and clarify their priorities for future investment. It consists of:

- a tool to assist countries in assessing existing policies and strategies;
- a tool to support countries to identify necessary data and information to aid policy and strategy development;
- a tool to help countries get started on actions; and
- a tool to enable countries to incorporate gender analysis into their child and adolescent health programmes and identify effective interventions that have a gender perspective.

Where does the Strategy “sit”?

The Strategy does not exist in isolation. It is linked to the health systems approach and is a reflection of, and an “umbrella” initiative for, a wide range of existing evidence-based initiatives currently being promoted by the Regional Office to support the health and development of children and adolescents.

Central to these is the United Nations Millennium Declaration and associated eight Millennium Development Goals (MDGs), which identify poverty reduction and human development as the cornerstones for sustaining social and economic progress.

The Millennium Development Goals are relevant to all countries in the European Region. Improving the health and well-being of children and adolescents, which is the ultimate aim of the Strategy, will help the countries meet their MDG obligations, particularly in relation to addressing hunger, reducing maternal and child mortality and tackling infectious diseases such as HIV/AIDS and malaria.

Implementing the Strategy

The Regional Office has been actively supporting Strategy implementation in Member States through a three-pronged approach:

- a situation analysis from participating countries, detailing information about the country profile, its health system organization, maternal, child and adolescent health status and challenges to supporting child and adolescent health and well-being;
- workshops held within the countries to introduce the Strategy, map current developments in child health and related programmes and determine a way forward at national level; and
- the development of national case studies identifying progress, challenges and successes.

The countries that have been offered support and their current stage of development are shown in Table 1.

Table 1. Countries offered WHO support and current stage of development

Countries who have received intensified support from WHO	Countries who have asked for intensified support from WHO	Countries with an advance draft of a child and adolescent health strategy	Countries with an approved child and adolescent health strategy
Albania Armenia Georgia Hungary Kyrgyzstan Moldova Romania Slovakia, Tajikistan Turkey Ukraine Uzbekistan	Azerbaijan Kazakhstan Ireland Russian Federation Turkmenistan	Armenia Georgia Kyrgyzstan Moldova Uzbekistan	Hungary Slovakia Tajikistan Ukraine United Kingdom (Scotland)* (Framework for Children in Scotland)

*Scotland does not actually have a separate strategy for child and adolescent health, but it has used the Toolkit to create a framework for children and young people in the country.

Where is the Strategy now?

The Regional Office has launched an in-depth evaluation of the implementation process for the *WHO European strategy for child and adolescent health and development* and intermediate outcomes. Findings are being published during the research to inform strategy development within Member States.

There are two parts to the evaluation. The first is a questionnaire-based *survey*, which is supplying simple data that can be generalized across countries and Regions. The second is a set of country-specific *case studies*.

The survey

The main purpose of the questionnaire-based survey is to collect information on the Strategy implementation process. It assesses political and organizational actions carried out as a result of Strategy implementation and provides comparable information from partners and national counterparts on specific aspects of the implementation process.

The questionnaire was sent to ministries of health in Member States. A baseline survey was carried out in 2006, with a follow-up in 2008. Of the 53 countries invited to take part, 20 have completed both surveys.

The survey focuses on many aspects of Strategy implementation, including indicators of political commitment, child and adolescent health services, information systems and human resources. A full report of the survey has been published. For the purposes of this document, we will focus on survey findings in relation to the four guiding principles of the strategy.

Reflecting a life-course approach in national strategies

Policies and programmes should address the health challenges at each stage of development, from prenatal life to adolescence.

The follow-up survey in 2008 found that the percentage of countries addressing different age groups in their national strategy had risen from 25% to 35%.

Around three quarters of countries have addressed the health needs of prenatal children in a national strategy. Almost as many explicitly address children between birth and 12 months, and 65% look at groups of children between ages 1–4, 5–9 and 10–19. There was much better representation of the 5–9 group in the 2008 follow-up survey; this group had been least represented in the 2006 baseline survey.

Thirty per cent of countries in 2008 acknowledged that the life-course approach had been adopted in their national strategies due to the influence of the *WHO European strategy for child and adolescent health and development*.

Creating equity

The needs of the most disadvantaged should be taken into account explicitly when assessing health status and formulating policy and planning services.

The 2008 follow-up provided evidence that countries are carrying out assessments of health gaps within or between different population groups to a larger extent than they

were in 2006, with almost three quarters detecting substantial inequities in child and adolescent health.

Different population groups are subject to different kinds of inequity. While relatively few countries in 2006 answered that they addressed inequity issues for different population groups in a national strategy, more than half of the countries can now state that they are doing so, with half of them acknowledging that this arises as a direct result of the European Strategy.

Promoting intersectoral action

An intersectoral, public health approach that addresses the fundamental determinants of health should be adopted when devising policies and plans to improve the health of children and adolescents.

This guiding principle signals the need to engage a wide range of sectors – health, education, finance, environment, social affairs, justice and the mass media, for example – with the national strategy to ensure widespread uptake.

The 2008 follow-up survey found that an intersectoral task force exists in 75% of countries. This reflects strong political commitment toward an intersectoral, joined-up approach to strategy development. Up to 30% of the countries acknowledge the influence of the *WHO European strategy for child and adolescent health and development* in developing intersectoral task force groups.

Encouraging participation

The public and young people should be involved in the planning, delivery and monitoring of policies and services.

Young people have a genuine interest in issues related to their health and well-being and have a right to a voice in decisions influencing their health enshrined in the *UN Convention on the Rights of the Child*. Participation of children and adolescents is crucial to the successful development and implementation of strategies, policies and services; adolescents are the experts on youth culture and are well placed to help in the design and running of youth-friendly services.

The 2008 follow-up survey shows that the proportion of countries involving young people in strategy development has increased from 30% to 45%. Young people are to a large extent being involved in the process through nongovernmental organizations (NGOs) such as youth parliaments and other youth movements.

In terms of wider public involvement, over half of the participating countries now involve NGOs in strategy development. This suggests that the process is opening up to a broader group of experts.

The case studies

The case studies provide in-depth and extensive analyses to assist future development in the case study countries and beyond. They aim to highlight best practice and lessons learned for countries currently implementing the *WHO European strategy for child and adolescent health and development* and for those who plan to implement in the future.

Two channels of information-gathering informed the case studies – narrative accounts and interviews (both individual and group). Five countries were asked to produce case studies focusing on:

- securing political commitment;
- addressing the Strategy’s four guiding principles (life-course approach, equity, intersectoral action, participation);
- strengthening health systems;
- improving information systems; and
- streamlining national strategies with international conventions and declarations.

Progress in each of the five case-study countries is summarized at Annex 2.

Some lessons learned from the case studies

Moving from policy to action and implementation is a continuous process and a positive start had been made in all countries. In terms of gaining finance for the implementation phase, most countries face a conundrum in that money is not being offered without the existence of a coherent, agreed strategy, and strategy development is being hampered by a lack of commitment to provide resources.

Political commitment is of paramount importance in making progress, and this commitment needs to be backed by strong political action and resource allocation.

The *life-course approach* is evident in the countries, although its application is not always coherent and there is a general perceived need to pay more attention to adolescent health in national strategies.

Higher priority needs to be given to identifying and meeting the needs of at-risk population groups to increase *equity*. Gender inequity issues are problematic; gender is starting to become more recognized as an equity issue in the countries and is now being incorporated in policies and actions, but in general, gender differences are still not being fully acknowledged within the area of child and adolescent health and gender expertise is missing in most of the countries. Gender issues should be addressed in a systematic way.

Intersectoral collaboration has been identified as a major strength across the case study countries, with ministries of health having an important leadership role. The extent of *integration with other policy developments*, however, varies widely between countries. Intersectoral coordination groups can also be adversely influenced by the instability of the political environment and by too many changes of representatives.

NGOs and other sectors have extensive experience in relation to *involving young people* in policy and strategy development, but youth involvement is not a widely practised activity within the health sector. Direct youth participation in the health sector needs to be initiated, perhaps through the brokerage of NGOs and the voluntary sector.

Where is the Strategy going from here?

The process of introducing the Strategy to countries in the European Region, supporting workshops and situation analyses to identify current situations and map future plans, beginning the task of developing strategies for individual countries and evaluating the process and outcomes is providing valuable lessons that can shape where the Strategy goes from here. Areas such as early childhood development, tobacco use in adolescence and costing of policies are becoming important issues for countries.

Analysis of the data from the baseline and follow-up surveys shows a substantial increase in the involvement of youth and civil society between 2006 and 2008. Life-course approaches and equity are being addressed to a larger (but not yet full) extent in national strategies, and the case study countries show the overriding importance of intersectoral collaboration. An intersectoral approach is at the heart of the process of developing and implementing the Strategy, but refining the process takes time.

The fact that the pattern of strategy development in each country reflects local priorities and existing strategies is a real strength, enabling local integration and progress. A balance needs to be struck between integration with local priorities and the need for shared definitions and milestones to enable Europe-wide integration.

Almost 40% of countries were receiving WHO technical support by the time of the follow-up survey in 2008, an increase of around 15% from 2006. Technical support was specified as information support, e-mail 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.

The evaluation analysis shows that WHO technical support is associated positively with a number of drivers for progress in strategy development, including the organization of a national workshop, inclusion of all age groups in the strategy and linking the strategy to the achievement of MDG's at national level.

Political will to support strategy development is evident throughout the countries, but conversion of will into action was not so well-disseminated. Only 17% of the countries in the follow-up survey claim that there have been government budgetary allocations or reallocations of dedicated resources for child and adolescent health as a result of the European Strategy. This basically means that work with the Strategy in most countries is being carried out without any additional government resources. Little by little, however, financial resources are being directed towards this area, and it is worth noting that the proportion of countries with specific financing for strategy development has doubled between 2006 and 2008.

One of the reasons for inconsistent financing for child and adolescent health may be the paucity of data on the subject. Robust data on child and adolescent health status and patterns are needed to support requests for resources, but the 2008 follow-up survey found that only around half the countries had a national database of relevant child and adolescent health information. In some countries, a database on child health does not exist as a single structure, but is integrated in other registers or databases.

Others see the four-yearly Health Behaviour in School-aged Children (HBSC) survey as a means of collecting information on social and behavioural issues that can be added to collected data on morbidity and mortality indicators, but the HBSC Study only looks at health behaviours in 11-, 13- and 15-year-olds.

Morbidity and mortality data are collected in most countries, with disaggregating being more and more frequently carried out, but data on socioeconomic conditions and on ethnic groups are still lacking.

The collection of disaggregated data is essential when it comes to respecting the guiding principles of the Strategy. Collecting disaggregated data is, however, a big challenge and is a demanding and time-consuming work task. There are nevertheless some encouraging signs of countries beginning to collect disaggregated data on, for instance, gender and age (disaggregated data on socioeconomic status and ethnicity is more challenging to obtain), with a rise from 4% to 17% in countries doing so. The introduction of the CHILD database as a template may be a good starting point.

In summary, the following points are suggested as being **necessary conditions for integrating the *WHO European strategy for child and adolescent health and development* into country policies and strategies:**

- integration of Strategy implementation with the health systems approach;
- identification of other strategies, gaps and unmet needs through a situation analysis;
- provision of leadership from health ministries (or most relevant ministry) for the situation analysis and for defining priorities;
- existence of political will and strong commitment and support from government to child and adolescent health and to intersectoral action;
- creation of a clear and common coordination system, sponsored by government, to coordinate stakeholders' activities, with a lead ministry identified and a high-level intersectoral working group put in place;
- definition of the status of the strategy document and the responsibilities of each sector for its implementation;
- definition of the financial and other resources each partner will contribute; and
- details of capacity-building priorities and a strategy for media relations.

Annex 1.

EUR/RC55/R6

European strategy for child and adolescent health and development

The Regional Committee,

Recalling World Health Assembly resolution WHA56.21 on the strategy for child and adolescent health and development;

Recalling its resolution EUR/RC53/R7 requesting the Regional Director to prepare a European strategy for child and adolescent health, in collaboration with Member States, and to present it to the Regional Committee at its fifty-fifth session, resolution EUR/RC52/R9 on Scaling up the response to HIV/AIDS in the European Region of WHO, resolution EUR/RC54/R3 on Environment and health and the Mental Health Declaration for Europe, Helsinki 2005;

Recognizing the right of children and adolescents to the highest attainable standard of health and access to health care, as set forth in internationally agreed human rights instruments;

Recognizing that the future health and prosperity of the Region will be determined to a large extent by the investments made in the children and adolescents of today;

Acknowledging that healthy children are more likely to become healthy adults and assets in the creation of a more productive society, and will make fewer demands upon the health system;

Noting that the improvement of child and adolescent health and development is closely related to the achievement of the Millennium Development Goals;

Conscious of the fact that health is determined by the physical, economic, social, family, school and other educational environments, as well as by the quality of health care provision, and that children and adolescents need a supportive environment, and one that also promotes gender equality, in which to grow and develop into healthy young adults;

Mindful of the many threats to the health of children and adolescents, from which no society, rich or poor, is immune;

1. ADOPTS the European strategy for child and adolescent health and development;
2. URGES Member States:
 - (a) 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;
 - (b) 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;

3. REQUESTS the Regional Director:

- (a) 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;
- (b) 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.

Annex 2.

Case study summaries

Albania

The process of preparing a national strategy for child and adolescent health and development in Albania started in January 2007, led by the Ministry of Health and supported by the Regional Office. The Ministry of Health concluded that there was a need for a national strategy and plan of action because of the child and adolescent health status in the country, the implications of ongoing health care reforms and country responsibilities under the MDGs.

The first step was a situation analysis conducted by a national group of experts using the Strategy Toolkit. This created a better understanding of the extent and causes of child and adolescent mortality and morbidity and the capacity of existing maternal and child and adolescent health services in the country. The analysis report was refined at a WHO-supported two-day workshop.

The four guiding principles of the European Strategy will provide the underpinning principles for the Albanian strategy. It will also be fully costed and will integrate with other health and development plans, the national Children's Rights Strategy, the MDGs and a major project looking at maternal and child health in Albania that is due to start in September 2008.

There has been strong political commitment to improving maternal and child health in Albania, with measures described within national health reforms. Improvement of maternal and child health is a high political priority and relevant stakeholders and partners are on board with the strategy development process; the Ministry of Health and Deputy Minister of Health have been particularly supportive. In addition, Albania is committed to achieving the MDGs.

This kind of political support is considered critical to the chances of developing a successful strategy for child and adolescent health, as is the continued provision of strong advocacy and support from WHO and other international partners.

Armenia

Armenia has had long involvement with the *WHO European strategy for child and adolescent health and development*. The country has been a pilot since 2005, held a Strategy-related workshop in 2006 and has been developing a case study since 2007.

Work is continuing with a view to having a child and adolescent health strategy included as a government decree sometime in 2008. A steering committee and working group have been established to take this work forward. Political willingness to improve and protect families, mothers and children is strong, and child and maternal health was a significant issue in the parliamentary and presidential elections of 2007.

The strategy development process has progressed smoothly, with the Ministry of Health taking the lead and receiving support and cooperation from stakeholders

including other ministries, NGOs, professional associations, United Nations Children's Fund (UNICEF) and WHO. Intersectoral collaboration has been considered successful, with partners actively involved. The intersectoral group, led by the Minister of Health, meets weekly and works with a range of subgroups. NGOs have been identified as key players in encouraging young people and wider society to participate.

A draft of the strategy has been prepared. It builds from the key guiding principles of the European Strategy and the results of the situation analysis carried out in the country to present strategic objectives, actions and monitoring mechanisms. A significant challenge has been found, however, in the breadth of the strategy's reach. A wide range of problems need to be addressed, covering legislative, policy, system, education, standard-setting, intersectoral and social mobilization issues, and each needs to be reflected in the strategy through specific interventions.

Plans for monitoring strategy implementation and descriptions of specific roles and responsibilities still have to be finalized, and general implementation will be dependent upon budgets. Integration with other related strategies is a challenge at both national and regional level, and instruments to harmonize strategies and priorities with the MDGs are needed.

The next challenge is implementation, which will require the commitment of resources. It is recognized that ongoing support from WHO and other partners will be crucial to ongoing progress.

Hungary

Engagement with the European Strategy began in Hungary in 2004, when the Strategy was considered nationally. This was followed in 2005 with the launch by the Prime Minister of the national infant and child health programme (NICHP), *Children: our common treasure*, which was developed through wide intersectoral collaboration involving various ministries, NGOs and scientific experts.

The NICHP has 13 defined goals which represent proposed solutions to issues raised in the country situation analysis.

Youth participation has been encouraged on at least two different levels. Nationally, good mechanisms have been established for engaging with the Youth Parliament. The picture locally at schools level varies, but school councils are in place in all parts of the country. Intersectoral collaboration has been pursued vigorously but remains a challenging process, especially when staff remits change frequently.

A national child and adolescent health conference, supported by the Regional Office, was held in September 2006. This focused on providing participants with further information about the European Strategy and Toolkit, reviewing the NICHP in the light of the European Strategy, and considering how other national programmes aiming to improve children's and young people's health and well-being could integrate with the NICHP.

A number of recommendations emerged from the conference, including the need to give a higher priority nationally to adolescent health, produce a greater commitment to intersectoral working and create better collaboration and integration with other

national programmes. These issues were also reflected in the work of developing the national case study, which commenced in 2007.

Since then, the national situation analysis has been completed and progress has been reported in a number of child and adolescent health areas. These include improvements in vaccination uptake, better screening for congenital metabolic diseases and a range of public health measures in schools, such as improved nutrition, safer playgrounds and injury-prevention initiatives. Less impressive progress has been made in terms of intersectoral collaboration and youth participation, the latter of which has not traditionally been a strength in Hungary.

The current situation sees a strengthening of the political commitment to implementing the NICHP. The programme was reviewed in May 2008 by the Standing Committee of Youth, Family and Social Affairs of the Hungarian Parliament. It recommended a series of changes, including creating clarity around priorities, ensuring priorities reflect resources, specifying roles and responsibilities, and determining monitoring systems. It is recognized that these changes have resource and financial implications.

United Kingdom (Scotland)

Scotland does not actually have a separate strategy for child and adolescent health, but it has used the Strategy Toolkit to create a framework for children and young people in the country.

A policy group on child and adolescent health has been created to advise the government minister with responsibility for health and well-being. The group includes representatives from education, social work and the voluntary sector as well as health.

Political will to improve child and adolescent health in Scotland is strong, with the well-being of children and young people identified as a priority area in the overarching policy statement for the National Health Service. Policy on child and adolescent health complements and supports initiatives in other sectors, including education, the environment and social justice. In addition, the country's Chief Medical Officer has led the development of a Task Force on Inequalities in Health, within which the importance of the very early years of life is seen as crucial.

There are many examples of initiatives designed to encourage youth participation in policy development in Scotland, including Young Scot, a national government-sponsored organization with active mechanisms for consultation and involvement, the Scottish Youth Parliament, a nationally representative body that has a health committee that is routinely involved in consultations, and Dialogue Youth, a local authority-based system set up to improve dialogue with young people.

There is not, however, a well-articulated or comprehensive life-course approach to policy development. Policy initiatives to cover various life-course stages (such as maternal and infant health) have been developed, but they have tended to arise in response to particular identified issues (such as high rates of maternal smoking in pregnancy and low breastfeeding rates among some parts of the population) and not as part of a coherent life-course approach.

Key successes include improved maternal and perinatal mortality rates, increased immunization uptake, legislation to support the Health Promoting Schools initiative and action to ban smoking in public places. Monitoring is a major priority, with national outcomes for health improvement being developed as part of performance management procedures for both health and local government. Routine data collection is well established.

Continuing challenges include developing effective intersectoral work for the 0–2 age group, addressing health inequities and tackling key health issues of obesity, alcohol misuse, low breastfeeding rates and infant and parental mental health and well-being.

Forthcoming policy on child health will focus on the early years and will be led from the Education Department. It will define a renewed political commitment to reduce inequalities.

Uzbekistan

Uzbekistan has shown strong political commitment to ratifying the UN Convention *on the Rights of the Child* and to developing a range of measures to protect and promote maternal and child health. This involves ratifying the *WHO European strategy for child and adolescent health and development* and putting in place a process for the development of a national child and adolescent health and development strategy for Uzbekistan.

The process of strategy development began in October 2007, followed by the establishment of an intersectoral working group in November 2007. The working group included representation from the ministries of health, education and labour and a number of NGOs and other organizations. They worked on drafting the strategy to meet defined key priority areas, with a draft being completed by April 2008 (coinciding with the designation of 2008 as the national “Year of youth”). The draft reflected the contributions that could be made by each of the sectors included in the working group.

An implementation plan has been prepared, involving presentation of the draft strategy to the Cabinet for approval. Different ministries will then have to approve particular action plans. Long- and short-term monitoring indicators have been identified and action plans will be revised on the basis of monitoring outcomes. A special citizens’ association will be formed to support the implementation process and promote community ownership.

The next steps include promoting discussion and ownership at regional level, assessing budgets and conducting a legal and financial audit, and strengthening the national partnership through inclusion of the private sector. Implementation will require technical support from WHO, The World Bank, UNICEF and others.



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