



**SDG target 3.2:** reduce neonatal deaths and deaths of children under 5 years, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.

## Fact sheets on sustainable development goals: health targets

# Child and Adolescent Health

A person's health at each stage of life affects health at other stages and has cumulative effects for the next generation. A poor start in life can lead to poor health, nutrition and inadequate learning, resulting in low adult earnings as well as social tensions (1). Therefore, the health and well-being of children and adolescents are essential for achieving the Sustainable Development Goals (SDGs) (2), particularly those targeting poverty, health security, education and the reduction of inequalities. Action is necessary across sectors and settings to support children and adolescents to survive, thrive and transform.

### Overview

Childhood and adolescence are recognized as critical stages of the life-course, during which many behavioural patterns that help to determine current health status and future health outcomes are established (3).

Newborns, children and adolescents face different health challenges. Beyond the health burdens of child mortality, neonatal conditions and vaccine-preventable diseases, young people face challenges of lack of access to quality services, violence and maltreatment, unhealthy lifestyles, neuropsychiatric disorders, drug and alcohol abuse, environmental exposures, climate change and even digital challenges (e.g. cyber-bullying and pornography, Internet addiction), among others (3). Risks to early childhood development remain high even in developed countries because of issues of social inequality, poverty, neglect and lack of developmental stimulation and opportunities (4).

Investment in children and adolescents, including the crucial first three years of life, will yield economic and social benefits beyond improved health outcomes, allowing them to grow and develop into prosperous adults (3,5–7).



## Child and adolescent health and SDGs: facts and figures



Child and adolescent health in the European Region shows continuous improvement, but there are important causes for concern over many of the target areas (Fig. 1).

**End preventable deaths of newborns and children under 5 years of age:** every year more than 160 000 children in the WHO European Region die before the age of 5 years, 50% of them in the first month of life (Fig. 1) (3,8). Many of these deaths are preventable.

- The most common causes of death in children under-5 years of age in the European Region are neonatal conditions (including prematurity, sepsis and birth asphyxia), injuries, pneumonia and diarrhoea (3).

**Halve the number of global deaths from road traffic accidents:** road traffic injuries are among the leading causes of death among children and young adults.

- The latest available data suggest that 39% of deaths among children and adolescents aged 5–19 years in the European Region were from unintentional injuries. The morbidity burden from road traffic injuries is many times higher (3).
- Road traffic accidents (23%), drowning (21%) and fire-related deaths (8%) are the major contributors to the annual 18 000 deaths from injury in children under 15 years of age (9).
- The implementation of effective interventions around the European Region would save many thousands of lives and considerable health care costs (9).

**Reduce the number of deaths and illnesses from environmental exposures:** poor indoor and outdoor air quality; inadequate water, sanitation and hygiene; mobility and transport patterns; hazardous chemicals; noise; and the combined effects of climate change are the most common environmental exposures associated with a high overall burden of disease among children and adolescents in the WHO European Region. WHO estimates that up to 26% of all global deaths in children under 5 years could be prevented if environmental risks were removed (3,10).

**Achieve universal health coverage:** in the European Region, progress has been made with the expansion of coverage of essential interventions for neonatal, child and adolescent health. However, there are still areas of improvement, particularly in relation to breastfeeding.

- The main issue is addressing quality of care, including the adoption of evidence-based guidelines for inpatient and outpatient management; reforms to health regulations governing admission and discharge criteria in line with patient-centred care; improvement of quality of training; availability of medical information; and systems to promote quality of care (11,12).
- Vaccines are among the most cost-effective interventions to reduce the burden of avoidable disease and mortality in young people. Yet, every year nearly 1 million children in the European Region do not receive all their scheduled vaccinations (3).
- The specific need for adolescent-friendly services has been neglected in many national child and adolescent health strategies (3).

**Reduce premature mortality from noncommunicable diseases:** mortality and disability could be significantly reduced for all ages by undertaking health-promoting and health-protecting activities in adolescence targeting noncommunicable diseases risk factors.

- Of the six WHO regions, the European Region is the most severely affected by noncommunicable diseases. Excess body weight, from excessive food intake combined with too little physical activity and low consumption of vegetables, fruits and whole grains are leading risk factors for noncommunicable diseases in the European Region (13).
- Over 60% of children who are overweight before puberty will be overweight in early adulthood (3). In the European Region, on average, one in three children aged 6–9 years is overweight

or obese (14). In the group aged 11–13 years, the prevalence of overweight (including obesity) varies from 5% to more than 25% in some countries of the Region (14).

- A considerable proportion of children and adolescents in many European countries do not meet recommended levels of physical activity (3).
- The promotion of healthy eating habits, including breastfeeding, are key levers to improve the nutritional status of young people, with an estimated return of €16 for every €1 invested (3, 13).
- The promotion and support of breastfeeding alone is estimated to prevent 12% of deaths in children under-5 in the European Region (3).

**Promote mental health and well-being:** mental problems among young people are a growing concern in the European Region.

- More than 10% of adolescents in the European Region have some form of mental health problem, with major depressive disorders being the most frequent conditions (3).
- The European Region includes countries with the highest adolescent suicide rates in the world, suicide being among the leading causes of death among young people in many settings with a proportion of 17.6% among those aged 15–29 years (15).
- Child maltreatment has far-reaching consequences for children, being the cause of almost a quarter of the burden of mental disorders; there are estimated to be 18 million child victims of sexual abuse and 44 million of physical abuse in the European Region (3, 16).

**Strengthen the prevention and treatment of substance and alcohol abuse:** alcohol use in early adolescent not only compromises adolescence development but also predicts health-compromising alcohol use later in life, with serious implications for public health (17).

- In the European Region, 25% of boys and 17% of girls aged 15 years report drinking alcohol at least once a week, and almost one third report having been drunk at least twice in their lifetime (18).
- Health-promotion strategies, such as health-promoting schools, adolescent-friendly services and social-marketing regulations aimed at addressing risky behaviours, have been initiated in the European Region, but they also need to be reinforced (3).

**Strengthen tobacco control in all countries as appropriate:** the European Region has some of the highest prevalence rates of tobacco use among adolescents, with a regional average of 12% for boys and 11% for girls (18).

- Among young people, smoking has short- and long-term health consequences, which are emphasized by the fact that most young people who smoke regularly continue to smoke throughout adulthood (19).
- Another cause of concern is second-hand smoke. Over half of all children aged 13–15 years are exposed to second-hand smoke at home in the European Region (20).

**Ensure universal access to sexual and reproductive health care services:** adolescence is a particular period of life where people can be empowered to know and exercise their sexual and reproductive health rights. However, far too many young people face barriers to sexual and reproductive health information and care in the European Region.

- Among 15-year-old adolescents, 25% have had sexual intercourse, but more than 30% in some countries are not using condoms or any other form of contraception (18).
- Support to improve sexual and reproductive health in adolescents requires action beyond the health sector and the use of integrated services, for example health-promoting schools and adolescent-friendly services (3).



Health-promoting educational settings that are inclusive, equitable and of high-quality contribute to better health and well-being, even regardless of family circumstances. Similarly, better health contributes to improved educational performance (3,21–23).

#### **Access to quality early childhood development, care and pre-primary education.**

- Investment in early childhood development, particularly in the first three years of life, enables children to develop their physical, cognitive, language and socio-emotional potential, with return rates of 7–10% across the life-course through better education, health, sociability, economic outcomes and reduced crime (Box 1) (3,4).
- Ensuring early and universal interventions in the educational sector, along with the promotion of good parenting practices and effective and equitable access to care, can play a crucial role in preventing exposure to risk factors such as alcohol, drug use and smoking, and can promote good sexual and reproductive health and mental health (Box 2) (3).



Findings of the Health behaviour in school-aged children (HBSC) studies show marked differences in health between boys and girls (18). Both positive and negative outcomes and behaviours are strongly gendered:

- Girls are more likely to have better diets and hygiene, while boys are more likely to be physically active (18).
- Female adolescents experience a different trajectory in relation to health and well-being indicators than males. Particularly, older female adolescents report a decline in subjective well-being. Negative health outcomes and risk behaviours include:
  - one in five girls, on average, reports fair or poor health by age 15 and half experience multiple health complaints more than once a week;
  - body dissatisfaction increases significantly during this period for girls, particularly in western and central European countries, despite actual levels of overweight and obesity remaining stable; and
  - 15-year-old girls have poorer mental health than boys and also report the lowest levels of life satisfaction, daily breakfast consumption and physical activity (18).
- Male adolescents experience injury, drink alcohol and smoke tobacco more often than girls, although the gender gap has been closing in some countries in recent years as girls adopt more risk-taking behaviours (18).
- Despite these concerns, encouraging trends in risk behaviours have been seen in the 2013–2014 HBSC survey results compared with earlier surveys, with substantial reductions in substance use, fighting and bullying victimization among boys and girls in many countries (18).



- There are rising inequalities among children in the European Region (4). Large variations have been observed in the prevalence between countries for many of the child and adolescent health indicators in the HBSC studies, reinforcing the importance of country-level factors and cultural norms in determining young people's health and well-being (18).
- Investments in the earlier periods of life from conception are the most effective way to further reduce the burden of mortality and disability among young people, reduce health and social inequity and promote the full development potential of all children (4).
- Obesity, physical inactivity, smoking, suffering from bullying, poorer communication with parents, antisocial behaviour, school drop-out and exposure to crime are more commonly observed in adolescents living in families of lower socioeconomic positions (18). For example, an estimated 27% of all adolescent obesity in Europe in 2014 was attributed to socioeconomic differences (18).



Maltreatment has far-reaching consequences for children, with poorer mental and physical health and worse social outcomes, including a propensity to be a victim or perpetrator of violence in adolescence and later life.

- Child maltreatment is a significant problem in the European Region; its prevalence ranges from 9.6% for sexual abuse (5.7% of boys, 13.4% of girls) to 22.9% for physical abuse and 29.1% for mental or emotional abuse (16).
- Annually, 850 children under 15 years of age in the European Region are victims of homicide (3). The rates of homicide in children under 15 years of age in low- and middle-income countries in the European Region are more than twice those in high-income countries (7 of 10 child homicide deaths occur in the former) (16).

Child maltreatment is a leading cause of health inequality and social injustice, with poorer and disadvantage population at greater risk. The health sector can play an important role in the reduction of child maltreatment prevalence, particularly as many of the consequences must be dealt with by the health sector. However, addressing the causes of child maltreatment requires coordinated, sustained efforts in multiple sectors (16).

## Commitment to act

Member States of the WHO European Region committed in 2014 to the European child and adolescent health strategy 2015–2020 (3), which aimed to enable children and adolescents to realize their full potential for health, development and well-being and to reduce their burden of avoidable disease and mortality.

### Box 1. Leaving no one behind...

**Giving every child a good start:** the first years of life are a time of tremendous opportunity and equally great vulnerability given the exceptionally strong influence that early experiences have on brain development. During this period, a stimulating environment, adequate nutrients and social interaction with attentive caregivers are required for optimal brain development (5). Although windows of opportunity for skill development and behavioural adaptation remain open for many years, trying to change behaviour or build new skills later on requires added work and investments (5).

The accumulation of adversities, beginning before conception and continuing throughout prenatal and early life, can disrupt brain development, attachment and early learning, and continue throughout life (24). Therefore, early childhood development is considered the most effective and cost-efficient intervention to address inequalities and to break the intergenerational cycle of poverty, with an estimated 17-fold return on investment with an increase in early childhood care and education services enrolment to 50% (24).

Interventions throughout early childhood and primary school (up to the age of 8 years) have been found to have benefits on adult wage earning; competence (e.g. intelligence quotient, educational attainment and general knowledge); health biomarkers; reductions in violence, depressive symptoms and social inhibition; and growth in the subsequent generation (5–7).

To achieve these aims, countries were invited to develop effective national strategies and policies on child and adolescent health and to set up mechanisms for their implementation and monitoring; this would involve all sections of government, guided by ministries in charge of health (3). The strategy provides a set of tools designed to support Member States in formulating their own national strategies (3).

In addition, the Global strategy for women's, children's and adolescents' health (2016–2030), launched by the United Nations Secretary-General in September 2015 and adopted in May 2016 at the 69th World Health Assembly, identified nine interconnected and interdependent areas of action as key to achieving the strategy's

aims: country leadership, financing for health, health systems resilience, individual potential, community engagement, multisector action, humanitarian and fragile settings, research and innovation, and accountability (2).

A more integrated and holistic way of working across sectors is required to make progress as no single sector or intervention can achieve the objective of supporting children and adolescents to survive, thrive and transform (2).

## Box 2. Intersectoral action

**Health promoting schools:** these play an important part in health promotion and in reducing health inequalities in Europe and worldwide. Health-promoting educational settings that are inclusive, equitable and of high quality contribute to better health and well-being; equally, better health contributes to improved educational attainment (25).

The more connected young people feel to their health-promoting school, the greater their emotional well-being and educational attainment (25). Strong evidence supports the effectiveness of health education covering mental health, healthy eating, sports and physical activity in schools (25).

Successfully establishing health-promoting schools within national educational systems takes time and requires:

- political will;
- partnership and mutual understanding between education and health sectors;
- leadership and support from school managers;
- building of ownership within the education system;
- recognition of local/regional initiatives within the national development programme; and
- relevant teacher training.

## Monitoring progress

The WHO Regional Office for Europe is developing a joint monitoring framework for the SDG, Health 2020 and noncommunicable diseases indicators<sup>1</sup> to facilitate reporting in Member States and to provide a consistent and timely way to measure progress. Child and adolescent ill health compromises all Health 2020 targets (26). The following, as proposed in the global indicators framework of the United Nations Economic and Social Council (ECOSOC), will support monitoring progress in supporting children and adolescents survive, thrive and transform (27). WHO is also documenting the uptake of the European child and adolescent health strategy in Member States and actions to bring national strategies in line with regional and global strategies.

### ECOSOC indicators

3.2.1. Under-5 mortality rate

3.2.2. Neonatal mortality rate

4.2.1. Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex

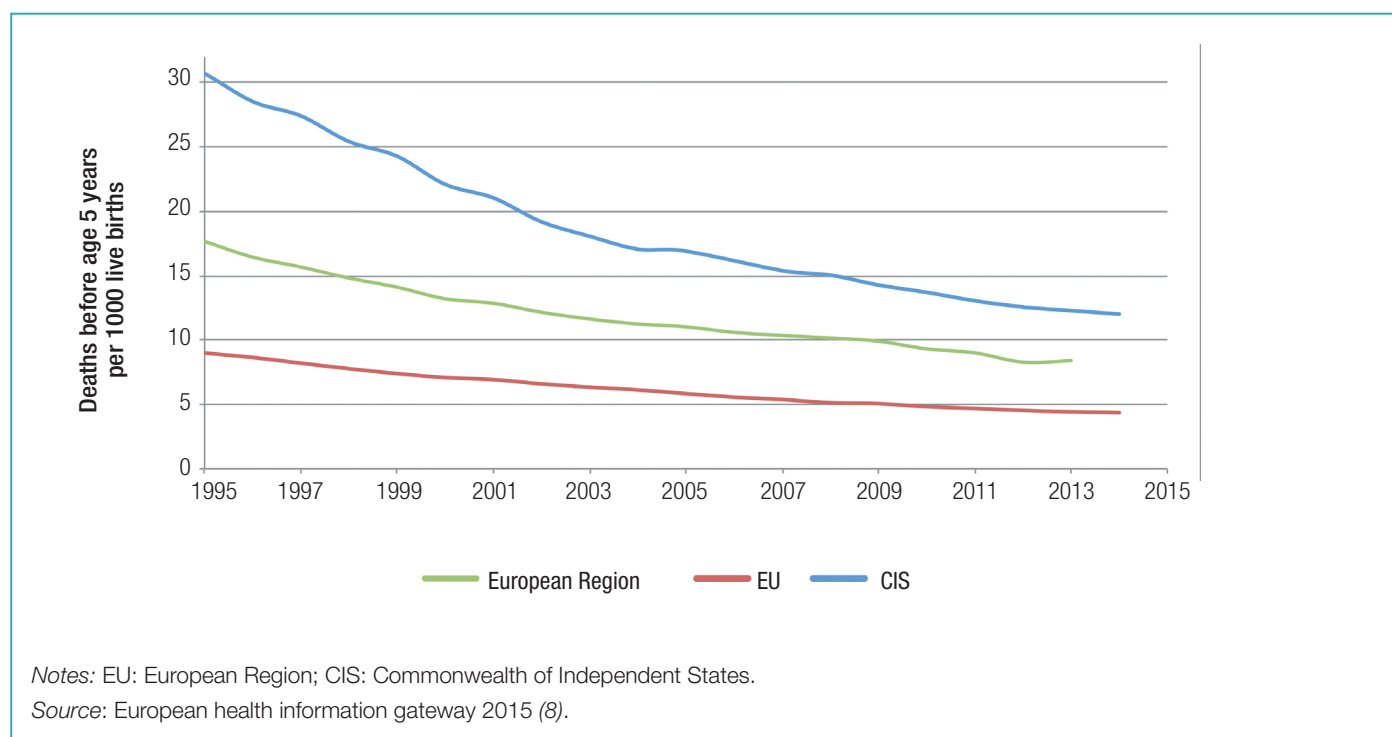
### Health 2020 core indicators

3.1.a. Infant mortality per 1000 live births, disaggregated by sex

3.1.c Proportion of children of official primary school age not enrolled

<sup>1</sup> EUR/RC67/Inf.Doc./1: joint monitoring framework: proposal for reducing the reporting burden on Member States.

Fig. 1. Probability of dying before the age of 5 years, per 1000 live births in the European Region, 1995–2015



## WHO support to its Member States

WHO, as part of its mandate, develops standards and guidelines for child and adolescent health policies, strategies and interventions and provides technical support and guidance for:

- policy development for children and adolescents (e.g. through the global and European child and adolescent health strategies (2,3) and the Partnership for maternal, newborn and child health (28));
- capacity-building for implementation of child and adolescent health strategies and intervention packages at national and regional levels;
- improvement in the quality of care for children and adolescents (e.g. the regional framework for improving the quality of care for reproductive, maternal, neonatal, child and adolescent health in the WHO European Region (12));
- improvement of surveillance, monitoring and evaluation systems (e.g. the HBSC cross-national survey (29)); and
- facilitation of intersectoral collaborations, such as the health, education and social sectors (e.g. through the Schools for Health in Europe network (23)).

The WHO Regional Office for Europe supports Member States in the implementation of the European child and adolescent health strategy (3). It is also involved in specific priority projects, often co-funded by other partners with additional back-up and expertise from WHO country offices (30).

The WHO Regional Office for Europe also collaborates in the HBSC cross-national study, which has provided information about the health, well-being, social environment and health behaviour of boys and girls aged 11, 13 and 15 years in 44 countries since 1983 (29). The findings of the study are published every four years as a flagship publication by the WHO Regional Office for Europe for use to inform policy-making for adolescent health throughout the European Region (29). Access to the data is readily available online.

## Partners

WHO collaborates with the following partners to support children and adolescents survive, thrive and transform:

- United Nations Children’s Fund
- United Nations Populations Fund
- United Nations Educational, Scientific and Cultural Organization
- European Commission
- Organization for Economic Co-operation and Development
- Schools for Health in Europe network.
- European Training in Effective Adolescent Care and Health
- HBSC survey network.
- WHO collaboration centres.

## Resources

- Investing in children: the European child and adolescent health strategy 2015–2020  
[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/253729/64wd12e\\_InvestCAHstrategy\\_140440.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0010/253729/64wd12e_InvestCAHstrategy_140440.pdf?ua=1)
- Global strategy for women’s, children’s and adolescents health (2016-2030)  
[http://www.who.int/pmnch/media/events/2015/g\\_s\\_2016\\_30.pdf](http://www.who.int/pmnch/media/events/2015/g_s_2016_30.pdf)
- European vaccine action plan 2015–2020  
[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/257575/64wd15e\\_EVAP\\_Rev1\\_140459.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0004/257575/64wd15e_EVAP_Rev1_140459.pdf?ua=1)
- HBSC survey  
<http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/health-behaviour-in-school-aged-children-hbsc/about-hbsc>
- Global AA-HA! guidance  
[http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/what-is-global-aa-ha/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/what-is-global-aa-ha/en/)

## Key definitions

**Adolescent-friendly health services:** inclusive, comprehensive and effective services that are accessible, acceptable and appropriate for adolescents; in the right place at the right time at the right price (free where necessary); and delivered in the right style to be acceptable to young people (31).

**Patient-centred care:** management and delivery of health services such that people receive a continuum of health promotion, health protection and disease-prevention services, as well as diagnosis, treatment, long-term care, rehabilitation and palliative care services, through different levels and sites of care within the health system and according to their needs (32).

**Recommended levels of physical activity (5–17 years of age):** includes play, games, sports, transportation, chores, recreation, physical education or planned exercise, in the context of family, school and community activities. The recommendations to improve cardiorespiratory and muscular fitness, bone health and cardiovascular and metabolic health biomarkers (33) are:

- at least 60 minutes of moderate-vigorous-intensity physical activity daily;
- physical activity for longer than 60 minutes provides additional health benefits;
- most of the daily physical activity should be aerobic; and
- vigorous–intensity activities should be incorporated, including those that strengthen muscle and bone, at least three times per week.

## References

1. A healthy start in life. Geneva: World Health Organization; 2002 ([http://apps.who.int/iris/bitstream/10665/67448/1/WHO\\_FCH\\_CAH\\_02.15.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/67448/1/WHO_FCH_CAH_02.15.pdf?ua=1&ua=1), accessed 16 August 2017).
2. The global strategy for women’s, children’s and adolescents’ health (2016–2030): survive, thrive, transform. New York: Every Woman, Every Child; 2015 ([http://www.who.int/pmnch/media/events/2015/g\\_s\\_2016\\_30.pdf](http://www.who.int/pmnch/media/events/2015/g_s_2016_30.pdf), accessed 16 August 2017).
3. Investing in children: the European child and adolescent health strategy 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/253729/64wd12e\\_InvestCAHstrategy\\_140440.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0010/253729/64wd12e_InvestCAHstrategy_140440.pdf?ua=1), accessed 16 August 2017).
4. Velea R, Tamburlini G. Early child development in the European Region: needs, trends and policy. Copenhagen: WHO Regional Office for Europe; 2014 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/254641/Early-child-development-in-the-European-Region-needs,-trends-and-policy-development-Eng.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0004/254641/Early-child-development-in-the-European-Region-needs,-trends-and-policy-development-Eng.pdf?ua=1), accessed 16 August 2017).
5. Black MM, Walker SP, Fernald LCH, Anderson CT, DiGirolamo AM, Lu C et al. Early childhood development coming of age: science through the life course. *Lancet*. 2017;389(10064):77–90.



6. Britto PR, Lye SJ, Proulx K, Yousafzai AK, Matthews SG, Vaivada T et al. Nurturing care: promoting early childhood development. *Lancet*. 2017;389(10064):91–102.
7. Richter LM, Daelmans B, Lombardi J, Heymann J, Boo FL, Behrman JR et al. Investing in the foundation of sustainable development: pathways to scale up for early childhood development. *Lancet*. 2017;389(10064):103–18.
8. Health for all explorer: European health information gateway [website]. Copenhagen: WHO Regional Office for Europe; 2017 (<https://gateway.euro.who.int/en/hfa-explorer/>, accessed 15 August 2017).
9. Sethi D, Towner E, Vincenten J, Segul-Gomez M, Racioppi F. European report on child injury prevention. Copenhagen: WHO Regional Office for Europe; 2008 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/83757/E92049.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0003/83757/E92049.pdf?ua=1), accessed 16 August 2017).
10. Fifth Ministerial Conference on Environment and Health: protecting children's health in a changing environment. Copenhagen: WHO Regional Office for Europe; 2010 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/123565/e94331.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/123565/e94331.pdf), accessed 16 August 2017).
11. Duke T, Keshishyan E, Kuttumuratova A, Ostergren M, Ryumina I, Stasii E et al. Quality of hospital care for children in Kazakhstan, Republic of Moldova, and Russia: systematic observational assessment. *Lancet*. 2006;367(9514):919–25.
12. Improving the quality of care for reproductive, maternal, neonatal, child and adolescent health in the WHO European Region: a regional framework to support the implementation of Health 2020. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0009/330957/RMNCAH-QI-Framework.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0009/330957/RMNCAH-QI-Framework.pdf?ua=1), accessed 16 August 2017).
13. European food and nutrition action plan 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 (<http://www.euro.who.int/en/publications/abstracts/european-food-and-nutrition-action-plan-20152020>, accessed 16 August 2017).
14. WHO European childhood obesity surveillance initiative (COSI) [website]. Copenhagen: WHO Regional Office for Europe; 2015 (<http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/activities/monitoring-and-surveillance/who-european-childhood-obesity-surveillance-initiative-cosi>, accessed 16 August 2017).
15. Data and statistics [website]. Copenhagen: WHO Regional Office for Europe; 2017 (<http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics>, accessed 16 August 2017).
16. Investing in children: the European child maltreatment prevention action plan 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0009/253728/64wd13e\\_InvestChildMaltreat\\_140439.pdf](http://www.euro.who.int/__data/assets/pdf_file/0009/253728/64wd13e_InvestChildMaltreat_140439.pdf), accessed 16 August 2017).
17. Adolescent development [website]. Copenhagen: WHO Regional Office for Europe; 2017 ([http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/development/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/development/en/), accessed 16 August 2017).
18. Growing up unequal: gender and socioeconomic differences in young people's health and well-being. Health Behaviour in School-aged Children (HBSC) study: international report from the 2013/14 survey. Copenhagen: WHO Regional Office for Europe; 2016 (Health Policy for Children and Adolescents No. 7; [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/303438/HSBC-No.7-Growing-up-unequal-Full-Report.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0003/303438/HSBC-No.7-Growing-up-unequal-Full-Report.pdf?ua=1), accessed 15 August 2017).
19. Health effects of smoking among young people [website]. Geneva: World Health Organization; 2011 ([http://www.who.int/tobacco/research/youth/health\\_effects/en/](http://www.who.int/tobacco/research/youth/health_effects/en/), accessed 16 August 2017).
20. Öberg M, Jaakkola MS, Woodward A, Peruga A, Prüss-Ustün A. Worldwide burden of disease from exposure to second-hand smoke: a retrospective analysis of data from 192 countries. *Lancet*. 2011;377(9760):139–46.
21. Schools and pre-schools promoting health and well-being for all children and adolescents. In: High-level Conference: working together for better health and well-being, Paris 7–8 December 2016. Copenhagen: WHO Regional Office for Europe; 2016 (Thematic paper 2; [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/324658/Thematic-Paper-2-Education.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0010/324658/Thematic-Paper-2-Education.pdf?ua=1), accessed 16 August 2017).
22. Barros AJD, Ewerling F. Early childhood development: a new challenge for the SDG era. *Lancet*. 2016;4(12)873–4.
23. SHE network [website]. Schools for Health in Europe; 2017 (<http://www.schools-for-health.eu/she-network>, accessed 16 August 2017).
24. Inequities in early childhood development: what the data say. New York: United Nations Children's Fund; 2012 ([https://www.unicef.org/lac/Inequities\\_in\\_Early\\_Childhood\\_Development\\_LoRes\\_PDF\\_EN\\_02082012\(1\).pdf](https://www.unicef.org/lac/Inequities_in_Early_Childhood_Development_LoRes_PDF_EN_02082012(1).pdf), accessed 16 August 2017).
25. School health promotion: evidence for effective action. Utrecht: Schools for Health in Europe; 2013 (Fact sheet 2; <http://www.schools-for-health.eu/pages-resources/she-factsheets-additional-information/read-more-she-network-factsheet-2>, accessed 16 August 2017).
26. Targets and indicator for Health 2020, version 3. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0011/317936/Targets-indicators-Health-2020-version3.pdf](http://www.euro.who.int/__data/assets/pdf_file/0011/317936/Targets-indicators-Health-2020-version3.pdf), accessed 15 August 2017).
27. Statistical Commission report E/2017/24 on the 48th session. New York: United Nations; 2017 (<https://unstats.un.org/unsd/statcom/48th-session/documents/Report-on-the-48th-session-of-the-statistical-commission-E.pdf>, accessed 15 August 2017).
28. Partnership for maternal, newborn and child health [website]. Geneva: World Health Organization; 2017 (<http://www.who.int/pmnch/en/>, accessed 15 August 2017).
29. About HBSC [website]. Copenhagen: WHO Regional Office for Europe; 2017 (<http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/health-behaviour-in-school-aged-children-hbsc/about-hbsc>, accessed 16 August 2017).
30. Children and adolescent health: country work [website]. Copenhagen: WHO Regional Office for Europe; 2016 (<http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/country-work>, accessed 16 August 2017).

31. Adolescent friendly health services: an agenda for change. Geneva: World Health Organization; 2002 ([http://apps.who.int/iris/bitstream/10665/67923/1/WHO\\_FCH\\_CAH\\_02.14.pdf](http://apps.who.int/iris/bitstream/10665/67923/1/WHO_FCH_CAH_02.14.pdf), accessed 21 August 2017).
32. ROADMAP: strengthening people-centred health systems in the WHO European Region. A framework for action towards coordinated/integrated health services delivery (CIHSD). Copenhagen: WHO Regional Office for Europe; 2013 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0005/231692/e96929-replacement-CIHSD-Roadmap-171014b.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0005/231692/e96929-replacement-CIHSD-Roadmap-171014b.pdf?ua=1), accessed 21 August 2017).
33. Global strategy on diet, physical activity and health: physical activity and young people [website]. Geneva: World Health Organization; 2017([http://www.who.int/dietphysicalactivity/factsheet\\_young\\_people/en/](http://www.who.int/dietphysicalactivity/factsheet_young_people/en/), accessed 21 August 2017).

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