

Development of national strategies - case studies from five countries

European Strategy for Child and Adolescent Health and Development



Health Promotion Programme

A Meyer University Children's Hospital
WHO Collaborating Centre for Health Promotion
Capacity Building in Child and Adolescent Health



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Development of national strategies – case studies from five countries

**European Strategy for Child and Adolescent
Health and Development**

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This document is a compilation of information gained through interviews and case study developments in selected countries in the process of developing national child and adolescent health strategies using the European Child and Adolescent Health and Development strategy. The case studies reflect the views of the contributors.

Foreword

Children's and adolescents' health is a resource for future economic and social development in all countries, whether of high, middle or low income. Early investment in the health of children and adolescents is important for many reasons.

The *WHO European strategy for child and adolescent health and development* was adopted by the WHO Regional Committee in September 2005. Its purpose is to assist Member States in formulating their own policies and programmes.

The European Strategy is based on a broad concept and understanding that views health in a life-course perspective. Such a starting-point requires us to focus on the stages of life that are decisive for development – pregnancy and birth, the first year of life, preschool age, from childhood to puberty, and adolescence – and calls for special efforts in promoting health and preventing and treating disease.

WHO Regional Office for Europe has been monitoring the development of the European Strategy in Member States through a cross-Europe survey and country case studies.

The cross-Europe survey set out to collect simple, comparable and generalizable data from as many countries as possible, and the case studies aim to inform about best practices and lessons learnt in the development process.

The case study process involved five countries (Armenia, Albania, Hungary, United Kingdom (Scotland) and Uzbekistan) with the aim of providing extensive descriptions and analysis on national experiences of developing strategies and policies for children and adolescents. The intention is that the information provided through the case studies can be used in countries currently developing national strategies based on the European Strategy.

The case studies also provide evidence of the added value of the European Strategy in the development of national strategies and policies by identifying improvement in relation to a better focus on:

- the four guiding principles of the European Strategy;
- health systems, specifically in a scaling-up of stewardship, resource generation, service delivery and financing; and
- integration of the Millennium Development Goals and the Convention on the Rights of the Child in national strategies.

Several of the case study countries have now approved (or are about to approve) their national strategies at cross-political level, and WHO aims to work closely with each of these countries in their efforts to finalize and implement action plans to improve health conditions for children and adolescents.

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Acronyms and abbreviations

ADB	Asian Development Bank
ALRC	Albanian Red Cross
ARC	American Red Cross
BCA	biennial collaborative agreement
CCA	common country assessment
CHILD	European Union project on developing indicators for child health
CRC	Convention on the Rights of the Child
CYPHSG	Children and Young People’s Health Support Group (United Kingdom, Scotland)
European Strategy	WHO European strategy on child and adolescent health and development
GDP	gross domestic product
HEAT targets	Health, efficiency, access, treatment targets (United Kingdom, Scotland)
HBSC	Health Behaviour in School-aged Children
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
HOPE/USAID	United States Agency for International Development Project HOPE
HPH	Health Promoting Hospitals
MDGs	Millennium Development Goals
NGOs	Nongovernmental organizations
NHS	National Health Service (United Kingdom, Scotland)
OECD	Organisation for Economic Co-operation and Development
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development
US\$	United States dollar
WB	World Bank
WHO	World Health Organization

Introduction

Scope and purpose of the case studies

The *WHO European strategy for child and adolescent health and development (1)* (hereafter referred to as the European Strategy) was adopted by the WHO Regional Committee in September 2005. The overall 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 European Strategy is designed to be of “practical help to Member States in formulating their own national strategies” by setting the key challenges in health and development from conception to maturity and proposing measures to address them.

The Child and Adolescent Health and Development Programme of the WHO Regional Office for Europe is monitoring implementation of the European Strategy. As part of the monitoring process, and in collaboration with the WHO collaborating centre for health promotion capacity building in child and adolescent health (Florence, Italy), case studiesⁱ on the country experiences of developing national strategies for child and adolescent health and development based on the European Strategy were prepared for Albania, Armenia, Hungary, United Kingdom (Scotland) and Uzbekistan.

Following WHO resolution EUR/RC55/R6 and its recommendation “to report ... on the progress and achievements made in developing and implementing child and adolescent health strategies in the European Region”, the purpose of these case studies is to provide evidenceⁱⁱ for policy-makers and practitioners on progress made in these five countries and on the extent of applicability of the European Strategy in formulating national strategies for child and adolescent health and development. The emphasis is on **strategy development**, rather than **strategy implementation**.

In particular, the case studies aim to report the **lessons learnt** from the development process and the **added value** of the European Strategy in the development of national strategies. The lessons learnt will focus on the following dimensions:

- the level of political commitment in relation to the development of a national strategy on child and adolescent health and development;
- the extent to which the four guiding principles of the European Strategy (life-course approach; equity; intersectoral action; and participation) are respected in national policies;

ⁱ For the purposes of this report, a case study is meant as “an uncontrolled observational study involving an intervention and outcome for more than one person”, and “is not supposed to replace technical or scientific documentation, rather to complement it by describing the gathering and the use of evidence in a narrative, anecdotal form” (2).

The case studies are meant to be mainly illustrative but include some perspectives from programme implementation: Case studies allow investigators to retain holistic and meaningful characteristics of real events – such as organizational and managerial processes (3).

ⁱⁱ WHO Regional Office for Europe defines evidence as: “Findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care” (2).

- the extent to which national health systemsⁱⁱⁱ are strengthened^{iv} in relation to three key functions: stewardship, health services and financing;
- the adequacy of information available on child and adolescent health issues; and
- the integration of the Millennium Development Goals (MDGs) (6) and the Convention on the Rights of the Child (CRC) (7) in national strategies.

These findings may be useful for countries currently developing and/or implementing national strategies based on the European Strategy and in countries where the implementation phase has not yet been initiated.

Findings emerging from the case studies should also identify the main challenges and recommendations for future actions in relation to the development and implementation of child and adolescent health and development strategies. This information may be of significance to the Regional Office in planning technical support for countries in the European Region.

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ⁱⁱⁱ *The world health report 2000* defines a health system as “all the organizations, institutions and resources that are devoted to producing health actions [and] include all the activities whose primary purpose is to promote, restore or maintain health”. It also defines four key functions of the health system: stewardship, resource creation, service delivery and financing (4). For the purpose of the case studies, “resource creation” and “service delivery” were merged and presented as “health services”.

^{iv} The Health Systems Action Network defines health system strengthening as “any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality or efficiency” (5).

Case study methodology and tools

Selection of the case study countries

The case studies were carried out between May 2007 and May 2008 in five selected countries: Albania, Armenia, Hungary, United Kingdom (Scotland) and Uzbekistan. These countries, which are at different stages of developing and/or implementing their national strategies based on the European Strategy, had expressed their interest in participating. Issues related to resources, epidemiology, institutions and infrastructure differ across the countries and influenced national strategy development; country-specific priorities and outcomes reflect this diversity.

The design of the study is holistic in the sense that the analysis is based on the assumption that the same elements of analysis are present within each case: the strategy, the change and the organizational field. Of course, this does not mean that the conditions and context are the same – on the contrary, it has been interesting to see how different interpretations are put into play within different contexts.

The study can be characterized as a holistic multiple-case design. Evidence from multiple cases is often considered more robust than that gleaned from a single case study (1). Cases do not represent a “sample” and are therefore not generalizable.

Table 1 summarizes the main steps carried out in four of the five countries.

	Participation in the pilot phase	Organization of a national workshop	National strategy was drafted	Strategy was officially adopted	Task force or working group was constituted	Beginning of implementation phase
Albania		X				
Armenia	X	X	X		X	
Hungary	X	X	X	X	X	X
Uzbekistan		X	X		X	

*United Kingdom (Scotland) does not have a separate strategy for child and adolescent health, but has used the European Strategy action tool to create a framework for children in the country.

Albania is at the very beginning of strategy development, while Armenia and Uzbekistan are further along in the process. Hungary started implementing the strategy two years ago. The countries therefore represent different stages of strategy development.

The case study process started in May 2007 following the first “WHO workshop on implementing the European strategy for child and adolescent health and development – lessons learnt” (30–31 May 2007), which was attended by the case study countries and WHO representatives. The aims of the case study workshop were to agree on the scope and purpose of the case studies and on the tools and steps of the process, making links to broader monitoring processes on implementation of the European Strategy. The process of case study preparation was created in a participatory and collaborative way in agreement with national actors. Findings emerging from the case studies were presented and discussed at a second WHO workshop held in Florence, Italy, on 29–30 May 2008.

Case study tools

The tools used to collect information for the case studies were questionnaires, narratives, individual interviews and roundtable discussions. An interview guide was developed to support the last two tools.

Case study questionnaires provided basic and comparable information that was further developed and investigated in the country interviews and narratives. A draft version of the tool was discussed during the first case study workshop.

Case study narratives were prepared by a national focal individual or team and provided a descriptive picture of country experiences in Albania, Armenia, Hungary, United Kingdom (Scotland) and Uzbekistan on implementing national strategies based on the European Strategy. The case study narratives include both factual descriptions and the authors' and co-authors' personal evaluations of the ongoing process. A case study template guided development of the narratives.

Individual interviews and roundtable discussions provided an opportunity to gather information and feedback on national processes from stakeholders representing different points of view and interests.

The main aim of the individual interviews was to access personal points of view from experts who had a comprehensive knowledge of the European strategy. The interviews were carried out with key people who participated in the development and/or implementation of a national strategy for child and adolescent health and development (including WHO staff in the country, representatives from national institutes of maternal and child health or their equivalent and members of special committees dealing with the development of a national strategy). Consequently, interviewees tended to have a very sound knowledge of their national strategy and the European Strategy.

Twenty-seven individual interviews were carried out. Each lasted about an hour, which enabled the interviewer to obtain exhaustive information on each of the subjects included in the interview guide (see below). The interviews were carried out as informal conversations, but were kept on track by the interview guide. There were at least three people present during all interviews: the interviewee, the interviewer, and an observer. Translation services were required for some of the interviews.

Two roundtable discussions were carried out in each country to allow different actors working within the field of child and adolescent health and development to share their actions, experiences and motives in developing and implementing a national strategy. This kind of interview makes it possible to observe interactions between the participants, which produce different information from that which can be gathered through individual interviews.

Consequently, the roundtable discussions had several purposes. They aimed to:

- collect information from many different actors within the field;
- allow people to meet and share their experiences through dynamic discussion; and
- provide information to the different actors about the strategy through discussions mediated by the interview guide.

Because of these multiple purposes, the roundtable discussions were not as structured as the individual interviews.

An interview guide was developed to keep the individual interviews and roundtable discussions on track. The questions in the interview guide are open-ended and focus on different processes in the development and implementation of national strategies for child and adolescent health and development. This means that most questions yield responses on “how” or “why” something is done, rather than providing information only on “what” is done. The same six-theme interview guide, which reflects the objectives of strategy development and implementation, was used for the individual interviews and roundtable discussions. The guide was pilot-tested in Armenia and was modified according to feedback on the questions and suggestions about other practicalities, such as the time required to conduct interviews and the need for definitions of concepts such as “political commitment”.

Selection of interviewees

The first step was to identify the group or organization in charge of development of the national strategy. Selection therefore relied upon professional contacts in the five countries as a means to identify potential interviewees.

Interviewees were provided with general information about the purpose of the interview and the study in advance. They were also informed that the results of the study would be disseminated within WHO and among international and national counterparts with an interest in the development and implementation of child and adolescent health strategies within different contexts.

The main purpose of the individual interviews was to obtain detailed information about the process of strategy development. Interviewees had to possess a comprehensive knowledge of the process, which meant that choice in most countries was restricted to people from a fairly limited work area – managers and decision-makers within the health sector.

Selection for the roundtable discussions focused on obtaining as much variety of opinion as possible through seeking to include people from different sectors, organizations and professional groups. Many different actors were consequently able to participate in the roundtables, producing a wide range of views and creating the opportunity to generate new and common understandings of strategy development. Criteria for selection for the roundtable discussions was more specific than for the individual interviews and the selection process proved to be more complicated.

The two roundtable discussions in each country were planned according to the different characteristics of the participants: one encompassed representatives from governmental bodies representing health and other sectors (mainly social, education, environment and finance), while the other consisted of representatives from nongovernmental bodies such as professional associations, faith-based organizations and international agencies, and health practitioners.

Analysis

This report analyses the information collected country by country. After presenting background information, it goes through the case study narratives and interviews for each country, summarizing the most important findings at the end of each country section. Results of the country-by-country analysis are then compared in the general conclusion section to highlight differences and similarities between countries in the process of developing and/or implementing their strategies on child and adolescent health and development. It describes the common lessons learnt, the added value of the European Strategy and the main challenges and related recommendations regarding, in particular, the development of national strategies on child and adolescent health and development.

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Case study – Albania

Background information on Albania

Albania is located in south-eastern Europe, in the western Balkan region. It has 3.1 million inhabitants and its population is younger than that of the average European country: it is estimated that about a third of the population is under the age of 15 years and 40% are younger than 18.^v

Emigration from Albania is significant. The Albanian National Institute for Statistics estimated that in 1991 more than 300 000 people left the country, including 40% of the population aged 19–40, and it appears that this movement may continue over the coming years. This phenomenon has led to estimates that by 2030, the percentage of young people in the population will decrease significantly, while the population aged over 65 years is predicted to double (2).

Despite a change in the urban/rural population ratio, there is still a higher percentage of people living in rural areas, which affects the well-being of children for a number of reasons. The World Bank (WB) estimates that about 30.3% of children in rural areas live in poverty,^{vi} against 21.9% in urban areas. The WB estimated that about 30% of children in the country aged 0–15 experienced poverty in 2002/2003 (the highest number being found in the western Balkan region), with the highest at-risk group being children between 0–6 years (28%). Under-five mortality rates (per thousand live births) declined from 45 in 1990 to 21 in 2003, although it is still very significant.

Nutrition is also an important problem in Albania. Growth stunting in children under five years was at 37% in rural areas and 24% in urban areas in 2000, which is higher than the prevalence in all countries of south-eastern Europe and in the Commonwealth of Independent States. Public health expenditure as a percentage of gross domestic product (GDP) dramatically decreased from 4.8% in 1991 to 1.2% in 1998, before increasing to 1.8% between 2002 and 2004 (3).

The biennial collaborative agreement (BCA) for 2008/2009 between the Ministry of Health of Albania and the Regional Office established different health priorities and objectives, of which the priority of “strengthening health system performance” and the objective of “improved maternal, child and adolescent health services” may have a particularly positive influence on child and adolescent health and development in the country.

^v Nuri (1) states:

In Albania, the information systems at all levels face enormous problems in collecting and processing data. The Institute of Statistics (INSTAT) acknowledges in its *Demographic yearbook 1990–1999*, that ‘during 1992–1999, the information on the total number of demographic events as well as on their structure by sex, age groups, place of residence, etc., is not complete’. In addition, the absence of a population census during these years makes the Albanian population figure just an estimate, one that may in fact be highly inaccurate. External and internal migration, as well as other important demographic phenomena, have not been taken carefully into account.

Therefore, many indicators may be distorted. The preliminary results of the 2001 census show a decrease in the Albanian population, from the INSTAT estimate of 3.4 million people to 3.08 million people.

^{vi} Data refer to all people and children aged 0–15 living in households where the current household consumption is less than US\$ 2.15 per person per day. Data are calculated from household budget surveys and living standards measurement surveys (3).

Case study narrative

Overview

Initiation of the national implementation process

The process of preparing a national strategy for child and adolescent health and development in Albania started in January 2007. The process was planned as part of the activities set out in the BCA through three main phases:

Phase I: situation analysis

Phase II: strategy document development

Phase III: official adoption of the strategic document and plan of action.

The Ministry of Health leads the process of preparing the strategy across all three phases.

The main reasons Albania needs a national strategy for child and adolescent health and development are related to:

- the health situation of the country;
- child and adolescent health status;
- health care reform; and
- international commitments for achieving MDGs, the national poverty reduction strategy and the process of European Union integration.

Funding and resource mobilization mechanisms

There are currently no foreseen allocated funds from the Government, but WHO, the United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) have proposed financial support.

Main actors in the development of the national strategy

The main actors involved in the process of preparing a national strategy for child and adolescent health and development are the Ministry of Health, National Institute for Public Health, the Albanian Society of Paediatricians and the Faculty of Medicine. The Ministry of Health leads and coordinates the work. The responsibilities and roles of each actor will be defined after the process of preparing the draft document commences. International donors such as WHO, UNICEF and UNFPA will provide technical and logistical support for the whole process.

Background and national context

Introduction and dissemination of the European Strategy

The Reproductive Health Sector within the Department of Public Health (Ministry of Health), which is responsible for maternal and child health, started the process of preparing a national strategy for child and adolescent health and development.

Distribution of the European Strategy document and related tools

The European Strategy and related tools were distributed to participants during the two-day national workshop.

Existing national strategy before September 2005

The process of adoption of the European Strategy in Albania started in January 2007. Taking into consideration the situation regarding child and adolescent health in the country, ongoing health care reforms and the MDGs, the Ministry of Health concluded that there was a need for a national strategy and plan of action for child and adolescent health and development. The Regional Office supported this initiative and it was included in the Albanian BCA.

National experiences of the development process

The national development process up to October 2007: main actions, outcomes and international support

The first step in the process of preparing a strategy in Albania was to conduct the national situation analysis, which provided a better understanding of the extent and causes of child and adolescent mortality and morbidity and the capacity of existing maternal, child and adolescent health services in the country. Analysis of data collected can be used to identify key gaps by comparing the existing situation with desired standards of health services and to prioritize and select interventions to address these gaps.

A national group of experts from the Ministry of Health and the Institute of Public Health was appointed to prepare the situation analysis for child and adolescent health based on the strategy tools of the European Strategy (assessment tool and information tool) and, as an outcome of this process, a final report was written. A WHO mission from Copenhagen assisted in finalizing the assessment and situation analysis in Albania and in facilitating the two-day national workshop on child and adolescent health.

The main objectives of the national workshop on child and adolescent strategies in Albania were related to:

- presenting the European Strategy to the Ministry of Health and other important stakeholders responsible for child and adolescent health and development in the country;
- evaluating the current situation, problems, policies and strategies related to child and adolescent health and development in the country;
- evaluating national child health programmes and other projects on child and adolescent health;
- identifying the resources and stakeholders needed to adopt the strategy in the national context; and
- identifying the possibilities and barriers in implementing a national strategy in Albania.

Thirty-five participants attended the two-day workshop, including representatives from the Ministry of Health, the Institute of Public Health, the Ministry of Labour and Social Affairs, nongovernmental organizations (NGOs) and major partners involved in maternal and child and adolescent health activities in the country, including WHO, UNFPA, UNICEF, the United States Agency for International Development (USAID), American Red Cross (ARC) and Albanian Red Cross (ALRC).

The first day consisted of plenary sessions and presentations from experts from the Regional Office and Albanian stakeholders. It focused on the child and adolescent health situation and programmes and policies based on the situation analysis report prepared in advance by the working group.

During the second day, participants were divided into groups according to priority populations for intervention defined in the situation analysis report: mothers and infants (0–1 year), children (1–10 years) and adolescents (11–18 years). Expected outcomes from the groups were:

- identification of all major stakeholders in Albania and definition of their current and potential role in the process of strategy development and implementation; and
- establishment and definition of functions of a coordinating body, including all major stakeholders, for developing a national strategy on child and adolescent health.

As part of this process, a country visit was carried out in November 2007 to prepare an Albanian case study on national implementation of the European Strategy. A team of experts from Regional Office visited Tirana for a five-day mission, during which they conducted interviews (two roundtable discussions and several individual interviews) with individuals from the Ministry of Health, NGOs and international donors in Albania, among others.

Main outcomes of the national workshop

The national workshop on child and adolescent strategies in Albania was held in January 2007 and its main outcomes were:

- a situation analysis of child and adolescent health and development status in the country based on the European Strategy assessment and information tools, prepared before the workshop; and
- a final report on the situation analysis containing detailed data on child and adolescent health and development status in the country.

The final report on the situation analysis integrated findings from studies and research carried out by several organizations and partners in Albania with existing policies and strategies regarding problems and challenges in improving the current situation. The Regional Office provided assistance in finalizing the assessment and situation analysis in Albania and in facilitating the two-day national workshop.

Influencing factors

Factors influencing the national strategy development process were the political will of the main policy-makers in relation to maternal and child health improvement, current health system reforms and the support of international donors in the country.

Use and applicability of the European Strategy tools

As was noted above, the European Strategy and related tools were distributed to participants during the two-day national workshop and the assessment and information tools were used in the preparation of the situation analysis.

Use of experiences from other countries

No experiences from other countries were considered during development of the national strategy.

Main lessons learnt from the national implementation process up to October 2007

Albania is currently going through political and economic transition and is experiencing changes in health priorities, which may slow down the process of strategy development. To prevent this, it is necessary to ensure ongoing commitment from decision-makers at the Ministry of Health throughout the process of strategy development; this is a critical influencing factor in

maintaining momentum and ensuring that the health sectors remain focused on working together to improve child and adolescent health.

There is also a need for stronger advocacy and support from WHO and other international partners such as UNICEF and from the highest level of decision-makers to secure greater commitment from all those involved in the process and define clearly stated and accepted responsibilities and roles for each. A specific advocacy plan needs to be prepared, particularly in relation to more difficult or sensitive policy issues, to target the most influential players.

A potential problem is an inadequate level of cooperation between some partners and resource people. Key partners must be fully involved throughout the development of the national strategy document and should endorse and support its implementation. In addition, limited financial resources to cover the escalating costs of some interventions and increasing dependence on donor support could slow down the process, especially during the third phase of implementation and evaluation.

Future actions

Next steps and key challenges of the national implementation process

The next steps of the national implementation process are the following.

- Formal endorsement of the national strategy on child and adolescent health and development by the Minister of Health.
- Formal establishment of a task force at national level, with the following responsibilities:
 - identify main partners and resource people involved in the national process of strategy development;
 - review and finalize the situation analysis and summarize interventions and actions;
 - identify the main components and contents of the draft strategy document based on the situation analysis and recommendations of the national workshop;
 - allocate responsibilities among small technical groups working on different items and issues of the strategy document (based on the priorities identified in the situation analysis);
 - prepare preliminary draft reports on various sections of the document completed by technical groups;
 - review and consolidate section reports; and
 - revise the whole document based on the task force's recommendations.
- During the process, the task force will:
 - coordinate all activities
 - advocate for the child and adolescent health and development strategy.
- Official adoption of the document through:
 - achieving national consensus for the draft strategy;
 - preparing a concrete plan of action for implementation, monitoring and evaluation of the strategy; and

- ensuring integration of the plan of action with other national and subnational health and development plans, timelines and budgets at different levels of the health system.

Planned future actions, expected outcomes and international support needed

Planned activities include the following.

- Gaining official approval for the preparation of the national strategy for child and adolescent health and development by the Minister of Health, to be promoted by the Public Health Directorate (Ministry of Health) immediately after the start of a maternal and child health project supported by the Spanish Government.
- Arranging a formal meeting to create a national task force, directed by the Deputy Minister, two weeks after the Minister's instruction to form the task force. The task force will select the people who will work on different issues regarding child and adolescent health (based upon the conclusions of the January workshop).
- Organizing a one-day workshop to present the European Strategy to the people who will work on the different issues, one month after the task force meeting.
- Starting the group work according to the priority areas selected with a view to preparing a written draft of the strategy.
- Organizing ongoing meetings of the task force with the groups to enable monitoring of their work.
- Preparing a final written draft of the strategy; a group of four people will collect the work of the three groups and will write the strategy draft.

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Analysis of interviews and roundtable discussions

Political commitment

Political commitment was recognized by all interviewees as one of the most important factors in the strategy development process. However, the actors also expressed their distrust towards politicians to a large extent. NGOs characterized political commitment as something imposed by international pressure. According to many actors, political commitment is temporary and unpredictable, which makes it impossible for stakeholders to rely on it. Lack of trust in politicians and lack of a stable political commitment was emphasized by governmental and nongovernmental actors.

The authorities have done almost nothing, and it is challenging to find a way to work with them. People working at ministerial level are not professional. And they do not have an idea of their job and what to do in their position. The work with the strategy is happening without public administration and professional capacities (representative, NGO).

Great doubt was therefore expressed about political commitment and political capacity. Regarding the implementation of policies and regulations, representatives from national institutes and interest groups expressed their reservations:

Some institutes have guidance and guidelines, and they are overstretched. When these rules are implemented, they do not take into consideration that they are damaging children's rights. There is a need to change the principles that these rules and regulations are based on (representative, national institute).

In the statement above, the implementation of rules and regulations is considered to be potentially harmful to children. Other actors stated that implementation of most rules and regulations is either nonexistent or unsuccessful, in the sense that implementation does not result in improved health status of the population. There seem to be many examples of interventions which, according to representatives from the national institutes, are never disseminated throughout the country, meaning that the remote areas where such initiatives are highly needed cannot benefit from them.

Coordination

A representative from the Ministry of Health described the need for coordination and integration of the national strategy on child and adolescent health with existing strategies and structures by comparing the political field to an orchestra:

In an orchestra everybody needs to play an instrument and that way everybody would play in harmony. So it cannot only be one person playing the big drum. With the strategy it is the same problem. It needs to be in line with the other strategies. I cannot say that this is the most important strategy (Ministry of Health).

All the players in an orchestra need to coordinate their instruments with those of the other orchestra members. As a parallel, it is emphasized that any particular individual strategy should not go "solo". According to the actors, there is a need to reflect surrounding information flows to be successful or to "play in harmony". If the strategy is not matched with the demands of other coexisting strategies, it will result in an unstable strategy development process and little synergy with concurrent initiatives.

Distribution of work tasks

A representative from the public health sector called attention to the fact that people from different sectors seemed to perceive work fields "vertically", with problems being passed "up" to other ministries because they are seen as being other ministries' problems:

There is a clear division and a clear separation between what is our responsibility and what is their responsibility. But, when we say 'clear division' and 'clear separation', this is in fact the danger. Because I think that you should never have such a clear division and separation of responsibility. Because we consider the health problems of children and adolescents as well as other problems that are not related to health care (representative, Ministry of Health).

This statement questions the benefit of a clear separation of responsibilities within the strategy development process. Several actors pointed out, however, that without clearly defined tasks and

responsibilities, people become confused. It is also emphasized that a strategy comes with an extensive set of responsibilities with which the key actor needs to comply.

Exercising responsibility is dependent upon authorization within the Ministry of Health. A participant at the roundtable discussions emphasized the fact that too many actors are being held responsible for delivery without having the mandate or authority to make the necessary decisions. According to this participant, it should be confirmed that the person who holds the responsibility is also able to take decisions. The speed of the strategy development process is perceived to be determined by the capacity and authority of the people in charge of the process.

The guiding principles

Youth participation

There is very little experience in Albania of direct involvement of young people. A youth parliament has been established, but very little work is done in collaboration with young people. There seems to be distrust within the health sector about the capacity of young people to participate in decision-making processes. There are nevertheless positive experiences within youth work groups in which young people have shown great initiative and have been included in social projects regarding legislation on alcohol consumption with great success. The youth parliament has also been included in decision-making processes within the social sector on several occasions, with positive outcomes.

Peer-to-peer education is regarded as an example of a project that enables youth involvement. UNICEF plays an important role in implementing this project, and effective guidelines on how to give young people a leading voice in the decision-making processes that relate to their own lives have been introduced. The peer-to-peer project is also a good example of the clear intention of government and international agencies to combine forces and contributions in one joint project. This project will hopefully encourage the Government to acknowledge the value of youth participation in decision-making processes.

The problem with youth participation at the current time is that it is rather unstructured and spontaneous. The impact of participation is consequently often very low, and interviewees mentioned that when it comes to working with youth groups, policy-makers possess neither the expertise nor the willingness to collaborate:

Youth participation only had a very low impact. The policy-makers didn't see the youth groups as helpers. The policy-makers do not know who the interest groups really are, so this is reflected in a culturally discriminating attitude. The policy-makers' attitude to the interest groups has to be different (representative, interest group).

Most of the stakeholders who were interviewed stated that young people should be the first to be consulted when developing a strategy for children and adolescents. Their participation should also be at a significant level. Youth involvement should not merely consist of receiving feedback from young people on a drafted strategy; young people should be an active part of the development process from the very beginning. According to actors with experience within the field of youth participation, young people are both willing and able to contribute to a strategy

Participation of civil society

NGO participants felt excluded from decision-making processes and perceived a reluctance from governmental participants to involve them. One participant specifically stated that there was no intersectoral collaboration and only limited involvement of the interested parties. Key players within the strategy development process expect a very limited number of people to be in charge, with little discussion with other relevant stakeholders.

The issue of lack of collaboration came up during roundtable discussions and in single interviews. Lack of agreement and opinion exchange, lack of coordination between ministries and lack of involvement of interest groups and professionals were stressed. It was also pointed out that involvement of other interested parties, apart from the Ministry of Health, is very limited. Channels for collaboration seem to exist, but the opinions of external actors are not taken properly into account.

There is neither the experience nor the motivation to involve civil society in the strategy development process at present, according to participants in the roundtable. It seems that the Ministry of Health is very hesitant to involve other parties.

Life-course approach

There is much talk about commitment to all age groups and the different stages within childhood and adolescence, but it was stated that this commitment is rarely followed up by concrete action plans that reflect different needs at the most vulnerable and critical stages. Actions tend to relate to curative activities, while health promoting activities are not divided into age-appropriate approaches. Interviewees nevertheless stressed that there was a great need to design the national strategy for child and adolescent health on a life-course approach. This would imply drafting the strategy in sections relating to specific age groups and looking at difficulties and shortcomings within each stage.

Stakeholders highlighted that the needs of adolescents were not being prioritized within the health sector at the moment, which means that adolescent lifestyle and health behaviour issues are not being sufficiently addressed. In particular, it was emphasized that sexual education for adolescents needs more attention.

Equity

Most inequity issues mentioned by the stakeholders related to the Roma population. Problems regarding registration of children were underlined as being central to this debate.

According to several stakeholders, the biggest problem with regard to the Roma population was that their culture and traditions were very different from those of the rest of the population. Because health services do not meet the needs of this population group and the Roma people tend not to comply with the general demands of the health system, they rarely receive appropriate treatments or interventions to address disease prevention or health promotion. Several actors stated that more research is needed to boost understandings of the mindset of the Roma population and to take the necessary measures to enable them to seek health care and register their children.

Another key issue is unequal access to health facilities due to geographical factors. Access to health services is particularly poor in the northern part of the country. Stakeholders also referred

to the large internal immigration from rural to urban areas in discussions on unequal access to services:

Definitely, children living in the areas where service provision is inadequate. In the northern part of country, many people have migrated. Health professionals have moved to Tirana, so there is clearly a service gap in this area. We have to define in the strategy how the Ministry of Health will go about this. There are probably solutions like mobile services and outreach services. But it is both the quality and the access (representative, roundtable discussion).

According to the stakeholders, these inequities should be addressed through the national strategy by developing a measurement framework for primary health care services. As one of the actors stated, the first thing to do is to identify and accept the inequities existing within the country; after this, measures can be taken to help at-risk population groups. This would imply that different programmes should be developed for different population groups, based on data that identify the specific needs and disparities of the groups.

Gender

There is a strong focus on women's and children's health in Albania. It has been the priority for a long period and is reflected in growing expertise in the area of maternal and child health. Gender expertise seems to be missing among decision-makers in Albania, however, with several actors emphasizing the great need for technical support to carry out a gender analysis.

A specific gender strategy is currently under development. One of the main pillars of this strategy is to advocate for the disaggregation of data to obtain information on gender inequities. Disaggregation, of course, does not only apply to health indicators, but also to several other fields where a gender perspective is relevant.

The Government has recently approved the gender strategy, which means that each of the ministries (including the Ministry of Health) is obliged to start implementing interventions and policies on gender-related issues. Consequently, there are good conditions and high-level commitment at the moment to incorporate the gender perspective into the national strategy for child and adolescent health. The integration of gender into the strategy still needs to be adapted to other guiding principles, such as the life-course approach:

The gender strategy will maybe give us the main objectives that should be in the strategy regarding the inclusion of gender into child and adolescent health. But the planned activities should be more concretely defined according to a life-course approach (Institute of Maternal and Child Health).

Intersectoral action

There was a common understanding among the actors that the health and well-being of children and adolescents is an issue that reaches beyond the responsibility of the Ministry of Health. Many stakeholders stressed that the strategy can play an important role in improving intersectoral action. The strategy should first of all be a document that creates a common understanding and a clear connection between the sectors in relation to child and adolescent health and development. It is therefore essential that several points of view are represented in the strategy and that it defines how political collaboration should take place.

There is a poor climate at present for intersectoral action at national, regional and municipal levels in relation to child and adolescent health. One of the tasks of the strategy is to create a good example of collaboration between sectors at national level. This would hopefully result in better interaction between stakeholders at local levels. It was pointed out that intersectoral action

was working in relation to other issues, and that this might serve as an example when establishing a working group to develop the national strategy for child and adolescent health and development. The main factor that will influence the working group's functioning is high-level commitment within each of the represented ministries.

It was a common point of view among the actors that all are to some extent responsible for children, which means that everybody has a responsibility towards developing a strategy. The Ministry of Health should be taking the lead, according to several stakeholders, but broader responsibility should be shared among ministries.

Improving health systems

Stewardship

Actors stated that a common understanding of the strategy is required. According to some interviewees, this involves sharing information and reporting back from meetings, in addition to changes in planning and requirements for funds to enable everyone to push in the same direction.

All stakeholders involved in the strategy development process seemed to agree that the health of women and children is a priority in Albania. There has been a systematic and rational division of work tasks within the health sector based on common priorities for the future generation and the rights of children, but some stakeholders (from the education sector) seemed to focus on the need to prioritize improvements in education, rather than health:

The stakeholders from other sectors do not feel that [health] is their priority, and sometimes they say it is secondary to their work. For example, people from the Ministry of Education, they say that their objective is to improve education and not health. They have other priorities, and then they postpone some of the aspects (representative, Ministry of Health).

Attention was drawn to the differing priorities between ministries which, according to the actors, cause arguments and confusion. These comments challenge the idea of one universal priority for all stakeholders. Consequently, actions are postponed and the commitment which was supposed to ensure the link between decision and action becomes vague. Formally, there seems to be a common understanding of the need to prioritize health, but this priority is jeopardized by the uncertainties that are introduced by different agendas of other sectors involved in the process.

Financing

It was felt to be extremely important to use funds for child and adolescent health in a more efficient way, particularly in relation to resources that need to be allocated to training and to establishing a steering committee. There will also be a need for budgetary allocations for each activity to make the action plan credible.

Financial allocations for the Ministry of Health are increasing year by year, but the problem is that resources within the Ministry of Health are usually not focused on specific interventions with specific population groups. International funding, such as that provided by the Spanish Government for the maternal and child health project, will provide some of the financial resources needed for the development and implementation of the strategy. Stakeholders underlined the need for tools to assess the costs of different activities planned for the implementation phase to ensure ongoing financial support for the strategy. Such assessment tools would be relevant for state funding and in relation to fundraising among international donors.

Health services

One of the most prevalent problems within the provision of health services is informal payments. These payments mostly apply to poorer people in the population who, as a consequence, have limited access to health services because they simply cannot afford them. The main reason for informal payments is that the salaries of health professionals are extremely low. The salaries of health professionals need to be increased to fight the informal payments system, alongside measures to increase their autonomy and ability to manage part of the budget.

Ongoing training for health professionals is an important element in improving the health system. Training is often arranged opportunistically or in relation to a time-limited project run by an international organization. It was emphasized by several stakeholders, however, that such courses only benefit a limited number of health professionals. Consequently, there is a need for more structured and continuous training programmes that ensure a unified approach to child and adolescent health. A positive factor is that most health professionals are extremely eager to receive extra training and to update their knowledge.

Information systems

Many actors emphasized that for everyone to push in the same direction, it is crucial to have access to systematic information that enables coordination:

There is no accurate or reliable health information. This lack of information makes us unable to predict or to estimate the costs or the budget. And due to this lack there is also a lack of financial support and financial planning and resource planning. Different figures from different sources make the system inaccurate. Because of this lack, the possibility of drafting plans and making policies disappears. And because of this gap in information, the decision-making is very difficult (representative, NGO).

In this quotation, a representative from an NGO expresses her doubts about the reliability of current health information in Albania. She also emphasizes that this has negative consequences for financial planning and the formulation of plans and policies. Several other actors expressed worries about access to reliable health information and the urgent need to streamline the information system regarding definitions and data collection. Stakeholders found it problematic that methods for data collection were inadequate, and several mentioned that accurate definitions and statistics were hard to come by. It is possible to informally observe urgent social and health needs among children, but reliable statistical evidence does not exist.

If the strategy is not supported by accurate and reliable information in relation to key contextual factors, participants fear that ill-informed decisions might be made, leading to inappropriate actions. It was emphasized that there is a need for transparency to allow identification of the means by which populations can be helped.

Declarations and conventions

Since 1991, health professionals, politicians and the rest of Albanian society have experienced various changes in values, conditions and technologies within the health system, which naturally challenge long-term planning in the country:

In our society, we are oriented towards Europe and the community, and all the new policy documents are prepared based on these principles. It is a good moment to use principles of the rest of

Europe in the strategy. Everybody agrees. And we have declared yes, and a strong yes. And now we have to put into practice, these principles (representative, national institute).

According to this stakeholder, the new orientation of Albanian society is towards Europe and the principles introduced by the European Strategy. There is a great willingness and common agreement about implementing the European principles. On the other hand, several stakeholders stated that it was pertinent to adapt the strategy to a national context instead of merely adopting a strategy that was general for all Member States of the European Region.

Orientation towards international society is highlighted in the following statement:

Political commitment is more enforced by the MDGs, with which the government has to comply. Rather than being needs oriented, many strategies are being developed exactly because the MDGs are there. The governments are then committed. Maybe the commitment is not for all of the right reasons, like for national interest. It is positive, even if it is external factors. The MDGs drive the work on the strategies (representative, NGO).

According to this statement, the MDGs play a key role in the development of national strategies. It is emphasized that the Government is committed to strategies with links to the United Nations' goals. Furthermore, it is stressed that although the reasons for this commitment are not necessarily complementary to national interests, the commitment is still important to the development of national strategies. International funding was also identified as an important influencing factor.

According to several actors, the national strategy for child and adolescent health and development should be adapted to contextual circumstances and, over time, to changes in priorities within the area of child and adolescent health and development.

Other considerations

Many actors explained that policies were rarely implemented in Albania. People seemed to shy away from large objectives, while more limited objectives and definition of concrete actions would be useful when trying to implement policies; actors found short-term objectives more concrete and easier to implement because they were process oriented.

The challenge of bringing the strategy into action was touched upon by many interviewees. A general opinion expressed by representatives – both governmental and nongovernmental – is that while the strategy document is relatively easy to develop, the challenge is to put it into practice:

Formulation and incorporation of objectives – it is not difficult. It is putting it into practice and to transform this kind of document into a document that enables the Ministry of Health to put it into practice. What will happen after this strategy has been signed? We need to know what happens after the strategy, and we want to have a signature by the Ministry of Health (representative, national institute).

The strategy document should therefore be transformed into a document that enables the Ministry of Health to implement actions. The first step in this direction is gaining commitment from the Ministry of Health itself.

Many actors stated that it is most likely that external circumstances will bring implementation to a standstill, while others focused on the strategy and its connection to implementation. It is clear from statements made that many policy documents are perceived as not being focused on reality,

which means that they will remain theoretical (and not practical) documents. Strategies are only successful if implementation is a part of the package, interviewees claimed. When strategy implementation is sporadic and unplanned, the strategy “disappears”. Strategies are to a large extent perceived as inadequate, formal structures. The actors see policy documents as formal but rather empty promises from governmental level, but defined budgets for implementation and action plans would help to ensure that the strategy delivers much more than empty promises. According to the stakeholders, an action plan must be in place before any implementation is attempted.

Summary of the Albanian case study

Albania is a country with a high proportion of young people aged 0–18 (40% of the population), which is reflected in the priorities of the BCA 2008/2009.

The country has not yet developed a national strategy draft, but the process was initiated in January 2007. Albania received international support from the European Region through the national workshop on child and adolescent health and development held in January 2007 and in finalizing the situation analysis. The WHO Country Office also supported, and will continue to support, the national process. There are no allocated funds for the strategy at the moment, but Albania’s future expectations are to receive financial, as well as technical and logistic, support from international organizations such as WHO, UNICEF and UNFPA.

The introduction of the European Strategy in the national context was initiated by the Ministry of Health through the Institute of Public Health. The European Strategy document and its tools were distributed during the national workshop on child and adolescent health and development to participants, and they were further used when preparing the situation analysis (assessment tool and information tool).

The main barriers encountered were limited financial resources, which may influence the sustainability of the implementation process, and the inadequate level of cooperation among important stakeholders. Enabling factors were the political will demonstrated by the main Albanian policy-makers regarding the need for improvement in maternal and child health, current health system reform and the support of international donors.

Findings from the process so far show that political commitment is perceived as temporary and unstable. Actors expressed distrust towards politicians and official rules and regulations. There is a clear need for harmonization with existing strategies in the country and the necessity to create more information to support decision-making processes. Finally, it was stated that too many actors were being held responsible for planning without possessing either the authority or the capacity to carry out the necessary actions.

Most stakeholders agreed that young people should be involved throughout the process of developing and implementing a national strategy. Although a youth parliament has been established, there is only very limited experience with regard to the direct involvement of young people within the Albanian health sector. Other sectors have more advanced experience in this, which might be seen as encouragement for the health sector to make youth participation more structured and less spontaneous.

There is much talk about commitment to all age groups and the different stages within childhood and adolescence, but it was stated that this commitment is rarely followed up by concrete action plans that reflect different needs at the most vulnerable and critical stages. Stakeholders defined a strong need for the national strategy to be based on a life-course approach.

The most prevalent inequities in health are related to the Roma population and to geographical factors influencing access to care. A suggestion was made that these inequities could be tackled by developing a measurement framework for primary health care services. There is a strong focus on women's health in Albania and a specific gender strategy was recently approved. This creates positive conditions for, and signals great commitment to, incorporating the gender perspective into the national strategy for child and adolescent health and development.

Stakeholders agreed that child and adolescent health was not a problem restricted to the health sector. They claimed that there was a poor climate of intersectoral action in this field, but that good practices exist in other areas. The strategy development process is seen as a potential catalyst for promoting intersectoral collaboration mechanisms in the field of child and adolescent health and development.

There is a common understanding about prioritizing child and adolescent health, but this priority is jeopardized by the uncertainties introduced by different agendas from other sectors involved in the process.

Financial allocations for the Ministry of Health are continuously increasing, but resources need to be allocated in such a way that training needs are also met. There is also a strong wish for the development and use of tools for cost assessment.

With regard to health services, the main problem identified derived from informal payments, which affect access to services. Another important element is training for health professionals: it was emphasized by stakeholders that training activities needed to be standardized at national level for all health professionals to receive equal and regular training.

The reliability of currently existing health information in Albania is considered to be low, with methods for data collection felt to be particularly inadequate. This has negative consequences for planning activities.

There is a strong commitment towards the achievement of the MDGs and they play a prominent role in the development and implementation of the national strategy. The issue of children's rights was not touched upon by Albanian stakeholders.

The key challenges for the future are to create the conditions for high-level commitment from the Ministry of Health throughout the whole process, to secure stronger advocacy from the main international actors and to establish closer collaboration among partners. Among the planned next steps are strategy development and its official adoption, along with the creation of a concrete action plan for implementation that includes monitoring and evaluation components. The action plan will be integrated with other relevant national or subnational plans in the field of child and adolescent health and development.

It is important to ensure that the objectives and goals of the Albanian strategy are process oriented and establish a close link to necessary action within the field. Unfortunately, too many policy documents are perceived as not being focused on the reality in Albania. To avoid this

accusation being levelled at the future national strategy for child and adolescent health and development, it is crucial to define clear budgets and action plans for each part of the strategy before implementation is initiated.

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Case study – Armenia

Background information on Armenia

Armenia is a member of the Commonwealth of Independent States (CIS) located in the south Caucasus region. The October 2001 census estimated the population to be 3.2 million, following the Spitak earthquake in 1988 and the mass population displacement as a result of the conflict in Nagorny Karabakh. It is also estimated that between 800 000 and 1 million people have left the country, with approximately 600 000 estimated to have emigrated between 1992 and 1997 (1).

Following independence from the Soviet Union in 1991, Armenia embarked on what has been called a “rapid ‘shock therapy’ strategy for economic reform”. Transition and consequent reforms brought serious long-term consequences to the income and well-being of the population. As Hakobyan et al. report, “life expectancy is relatively low and poverty levels are sizeable, while officially reported adult literacy and educational attainment have remained high” (1).

Poverty in children is very high in Armenia, affecting over half of the child population. The World Bank estimated that for 2002/2003, 54% of children were living under the absolute poverty line, in comparison to 50% of adults. The group at highest risk was children aged between 0–6 years, of which 58% were considered to be living in poverty.

Under-five mortality rates in the Caucasus and central Asia region tend to follow the very high levels of child income poverty, and Armenia replicates this trend. Its under-five mortality rate in 2003 was 33 deaths per 1000 live births, although this reflects a fall by almost half from 1990, when the estimate was 60 deaths per 1000 live births. Children living in households in the poorest wealth quintile are twice as likely to die before their fifth birthday as those in the richest quintile.

A similar picture is found in relation to the nutritional status of children, with 19% of children under five years in the lowest quintile being growth-stunted or underweight, against 9.3% of those in the richer quintile (2000 figures). The difference between urban and rural prevalence of stunting among children less-than five years is also significant, with 16% of children in rural areas affected against 10% in urban (2000/2001 figures).

Public health expenditure as a percentage of GDP dramatically decreased from 3.2% in 1991 to 1.4% between 2002 and 2004. Survey data from 1999 showed that 91% of patients had made informal payments, and it is estimated that over 70% of total health expenditure was made by households rather than the state (2).

The biennial collaborative agreement (BCA) between the Ministry of Health of Armenia and the Regional Office for 2008/2009 established health priorities and objectives, of which the priority of “strengthening health system functions” and the objectives of “[improving] maternal and child health” and “[enhancing] surveillance and response to communicable diseases” may have a particularly positive influence on child and adolescent health and development.

Case study narrative

Overview

Initiation of the national implementation process

The implementation process for a national strategy based on the European Strategy was initiated in 2006 by the Ministry of Health through the Institute of Child and Adolescent Health, in collaboration with, and with support from, the Regional Office and the WHO Country Office in Armenia. Motivating factors included concerns about the health status of children and adolescents, emerging health threats and the need to review existing policies and programmes and assess their overall effectiveness. Contacts and collaboration between the lead sector and the Regional Office had been established in 1994.

Funding and resource mobilization mechanisms

The Government funds most health sector services for children, including outpatient (fully) and inpatient services (partially). Other sources of funding include donations from international, bilateral and nongovernmental organizations.

Main actors in the development of the national strategy

The leading actors include: Ministry of Health (represented by the Deputy Minister); Director of Mother and Child Health Division; Scientific Head of the Institute for Child and Adolescent Health; and the Head of the National Centre for Child Health Care Organization and Methodology. Other experts, identified through their previous experience and current position, are also involved in the development of the national strategy. The actors work closely together under the general guidance of the Scientific Head of the Institute for Child and Adolescent Health. The Regional Office provides technical support through country visits by WHO officers and experts and by supporting key actors' participation in relevant meetings and workshops throughout the WHO European Region.

Background and national context

Introduction and dissemination of the European Strategy

Introduction and dissemination of the European Strategy was carried out by the leading actors through national meetings, forums and dissemination of materials to interested parties. WHO initiated and participated actively in the series of meetings held in Armenia.

Main outcomes of the specific national/local workshops and training courses

The main outcome of the different activities was the draft of the national strategy and development of a mechanism for multisectoral collaboration involving relevant ministries, associations and NGOs.

Distribution of the European Strategy document and related tools

The Government received the documents through the WHO Country Office and distributed them at relevant meetings and through direct dissemination among health policy-makers.

Description of the existing national strategy before September 2005

The Mother and Child Health Care Strategy was adopted in 2003. This partially covered the ground described in the European Strategy.

National experiences of the development process

National development process up to October 2007: main actions, outcomes and international support

Armenia was selected as a pilot country for developing and implementing the European Strategy in 2004. A team of officers and experts from the Regional Office visited the country in February 2005, and relevant documents and tools were tested with Armenian experts. The national workshop was held in November 2006, involving Regional Office staff, national policy-makers, experts and partner international and national NGOs.

A national team of experts was established. The team arranged a series of meetings during 2007 and initiated the drafting of the national strategy on child and adolescent health. The Regional Office assessed the process of development and introduction of the European Strategy in October 2007.

All these activities were carried out in close collaboration and with significant contributions from the Regional Office. The national team also participated in relevant WHO meetings, including those in Malaga, Spain in 2006 and in Florence, Italy in 2007.

Influencing factors

The activities described above significantly facilitated the process of strategy development, but the national implementation process was also influenced by factors such as lack of intersectoral collaboration and availability of relevant staff to participate in the process.

Use and applicability of the European Strategy tools

All tools (except the gender tool, which was not available at the time) were found to be very relevant and useful in developing the draft strategy.

Use of experiences from other countries

Generally, the experiences of many countries were considered in developing and introducing policies and programmes on child and adolescent health and development in Armenia. There is particular experience of long-term collaboration with partners in Switzerland, Belgium, France, the Russian Federation, Germany, the United States and Canada, among others. These collaborations cover a number of fields, including child development, child disability and rehabilitation, child psychology and chronic diseases in children. Existing policies reflected in the draft strategy consequently reflect international collaboration. The draft of the Hungarian strategy was also taken into consideration.

Main lessons learnt from the national implementation process up to October 2007

The main lessons learnt from the national implementation process are:

- a need for real and strong intersectoral collaboration;
- a need for large and prospective views of the goals of the national strategy, which should be truly comprehensive and focused on the future; and
- a recognition that the strategy should be realistic and feasible to implement.

Future actions

Next steps and key challenges of the national implementation process

The Government is expected to approve the national strategy by October 2008. The Ministry of Health will facilitate the process of completion of the strategy (other relevant ministries have

been invited to nominate members for the working group). Key challenges include developing a good working mechanism for intersectoral collaboration, clarifying approaches to financing and planning future implementation of the national strategy.

Planned future actions, expected outcomes and international support needed

Future actions include:

- completion of the strategy, including indicators for monitoring its implementation
- incorporation of gender and environmental issues into the strategy
- circulation of the document among interested partners
- submission to the Government
- approval by the Government
- monitoring, supervision and evaluation
- review of the curriculum of relevant undergraduate and postgraduate medical education institutions.

Technical support from WHO is requested for the development of the following:

- a monitoring tool to assess progress on strategy implementation (this may be different from the existing information and assessment tools);
- a costing tool for planning implementation and service delivery; and
- a tool to enable incorporation of the national strategy into undergraduate curricula.

Additional comments

Additional information on specific actions, decisions or collaborations that have proven especially important and useful for the national process

Some gaps exist between different child and adolescent fields; a more integrated approach is therefore needed.

Comments from stakeholders and organizations on the national development process

During discussions, the partner sectors raised the point that their role should be defined more clearly.

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Analysis of interviews and roundtable discussions

Political commitment

Many actors recognized that there has been ample expression of political commitment, but less in the way of concrete action:

Overall there is a commitment among all the political leaders that child and adolescent health receives high priority. And there are some cultural and historical values that make a standard that children are our future and we have to dedicate more energy and resources to this. However, there is more on paper than there is serious political action (representative, Ministry of Health).

Many actors touched upon the importance of personal attitudes, motivation and power. Strategy development was perceived as being reliant on the willingness, openness and behaviour of leaders. These elements are considered decisive for the adoption and incorporation of the strategy into the overall national programme and, consequently, for the future implementation of the strategy.

All stakeholders seemed to have substantial trust in one particular leader's ability to create positive progress with regard to strategy development and implementation. This leader is viewed as guiding the process and to be pushing and contributing to the launch of a new law on children's rights. The leader is also seen as a person who is able to turn political commitment into political action.

The guiding principles

Youth participation

According to several stakeholders, youth participation has been left out of strategy development. Several NGOs, however, are succeeding in involving young people – a good example is a peer-to-peer education project. NGOs have managed to include young people in discussions with very positive results, and this was suggested as a good entry point for involving young people in decision-making. Technical support should therefore be sought mainly from NGOs that have experience in the field.

It was stressed that there is a need to find the right mechanism for involving young people adequately in the process. The problem is that young people representing the adolescent population tend to come from a relatively high social level. It is therefore difficult to identify and

involve a section of young people who are genuinely representative of the entire population group.

Some stakeholders emphasized that it is important to have a draft of the strategy prior to inviting young people to participate in the process. Others highlighted that young people need to be taught in school how to participate and how to play an active role in decision-making processes. If they do not have this knowledge, it was suggested, their participation might be harmful to the process.

The overall impression, though, was a perception of great benefit from involving young people. It was recognized that they know their own needs better than anybody else.

Participation of civil society

Actors observed a tendency for strategy development to be restricted to a small group of people. There seemed to be ongoing negotiation between NGOs and governmental bodies about the strategy. NGOs were perceived as representing *real-life* knowledge, while governmental stakeholders were seen as possessing decision-making expertise. There is a clear interaction between different values, expectations and agendas that create the basis for negotiation between governmental and nongovernmental stakeholders.

The Institute of Child and Adolescent Health is regarded as the main developer of the strategy. Actors described how the process is being carried out by a small group of people, with involvement of other parties being restricted to advisory assistance. Fresh and independent participation within the strategy development group was needed, according to several actors, to introduce new ideas that will allow a more holistic approach to child and adolescent health and development to emerge.

Actors from NGOs stated that the Government does not seem to recognize the NGOs as partners in the strategy development process, and several members of civil society expressed their frustration about collaboration with governmental bodies. On the other hand, some governmental stakeholders indicated that NGOs failed to work within the common frame of governmental bodies, and that they only work for themselves and their own cause in trying to secure a major share of the financial resources. Others spoke mainly in favour of the NGOs and the potential contribution of civil society organizations. NGOs were described in this connection as the “watchdogs” of the work, ensuring that people working in the ministry were aware of what was going on within the field. NGOs’ diverse qualities were seen as assets in strategy development and implementation. Their close contact with the general population and their work with different target groups, which can be difficult to access and understand for other stakeholders, emphasized their role as the “entry point” for population involvement.

Life-course approach

Most stakeholders seemed to agree that adolescents are not given sufficient attention in health care or in health promotion. Few adolescent-specific activities exist in these areas, and there does not seem to be a systematic approach to the health of this population group. Adolescent health should be included in family medicine, but it was recognized that the process of doing so could be long and the outcome uncertain.

Different opinions were expressed about children’s health. Some stakeholders claimed that projects like the integrated management of childhood illness have ensured sufficient attention

towards children under five, but others stated that children are not visible in the system before they start school at around the age of seven years. Lack of registration at birth, which results in lack of surveillance and follow-up of children with disabilities, among other problems, is a recurring issue. People were therefore not able to agree on where the most significant health gaps lie, although there was wide agreement that some age groups are not getting the attention they need. This is illustrated by the following quotation:

In the health system it is like building with bricks. Sometimes a part of the building is damaged, and there are some gaps and sometimes we do not have any windows. Or there is a large hole in a wall. Gaps between ages is one of these holes (paediatrician).

Equity

Mental health issues create great inequities within Armenian society and are perceived as one of the most challenging issues within child and adolescent health. This is mostly due to the fact that treatment of mental illness in the past was only offered in psychiatric hospitals; consequently, children were institutionalized at a very early stage. This is now changing, but technical support is needed to carry out the adjustments that will create better conditions for children with mental health problems.

Actors also emphasized inequities in socioeconomic conditions, particularly the differences between rural and urban populations and poverty in general. It is important to stress that most stakeholders pointed to the fact that these inequities are impossible to address through special programmes. The overall health system should be dealing with inequities in terms of accessibility, which requires a fundamental structural change within the system. It was therefore suggested that the national strategy for child and adolescent health should not, and could not, play the main part in relation to inequity issues. It can, however, contribute to changes in system approaches by linking child health to the debate on inequities in society.

Most resources are directed through the strategy towards rural areas, and the community component of integrated management of childhood illness has emerged as an especially important factor in trying to improve health status within the rural population.

Gender

The gender issue was regarded as one of the weak points within the Armenian strategy development process. The gender concept is starting to be better recognized and acknowledged within the health sector, but some people still shy away from talking about gender inequalities:

This is a delicate topic because in Armenia, we do not like the word 'gender'. At least some people. But we made big progress in terms of understanding what gender is. This also happened in other ministries. So now they know and they remember what gender is. But they do not like to talk about it (Institute of Mother and Child Health).

Gender analysis was incorporated in the reproductive health strategy. Stakeholders agreed that the gender issue should not be set as a priority in itself, but should feature across the entire strategy. Most professionals and political decision-makers, however, believe that gender is only about women's rights, which presents a problem in relation to acknowledging and understanding the wider gender concept. There is therefore no common understanding that the gender debate should be dealing with the health and the rights of *both* sexes. It is increasingly recognized that while girls and women are targeted through the reproductive health approach, which has been in existence for many years, there are no interventions directed explicitly towards the health and well-being of men and boys in Armenia.

The lack of data disaggregated by sex is a significant barrier to the incorporation of a gender perspective into programmes. Morbidity data, for example, are not disaggregated by either sex or age. It was also stated that there is a substantial lack of knowledge on how to effectively incorporate gender into different programmes.

Intersectoral action

Intersectoral collaboration attracted criticism from many actors, with little perception of integration of ministries. Ministerial programmes were described as being “vertical”, and stakeholders stated that there was an ongoing struggle between the ministries regarding ownership of different programmes. Both governmental and nongovernmental stakeholders declared that there were many conflicting interests between sectors and that political leaders had different understandings, ambitions and reasons to protect themselves and their area of work.

Many stakeholders pointed to the existence of contradictory interests which impede the participation of some groups and worsen the day-to-day collaboration of others. Stakeholders should nevertheless still strive to improve collaboration through clearly defined tasks; in other words, there is a need for a systematic approach to make collaboration work.

Improving health systems

Stewardship

Actors stressed the fact that setting priorities is a complex matter that requires consensus among many different stakeholders. Furthermore, information is needed to support the decision of putting one health-related problem above another:

“How can you prioritize the different health issues? They are all important. They are all equal. Disabilities, reproductive health ... How do you do that?” (representative, NGO)

Many stakeholders emphasized that without clear priorities, decision-makers were not able to decide on the next steps in long-term planning. According to the actors, setting priorities makes it easier to predict the future needs of society and decide on what should be done to meet these needs. It was stressed that to be helpful for future planning, the many different priorities should be grouped and sequenced in order. To many stakeholders, however, it did not seem appropriate to prioritize health issues when most of them appear equally important.

Actors believed that prioritization can be achieved through negotiation among knowledgeable stakeholders. Prioritization was characterized as being dependent on technical capacity, the presence of relevant experts and availability of grants through project proposals. Several actors strongly acknowledged that to support action on the different priorities identified, contextual factors such as expertise, evidence and funds should be included in the planning process. There therefore needs to be a balance between a practical approach (what are we able to do?) and a more idealistic approach (what is needed from us?).

Financing

The health budget has been increasing substantially during the last five to ten years in Armenia, but financial flows and allocations within the health sector were perceived to be highly unpredictable:

There is a tendency to increase financial resources. But it is far from covering real needs. State money will be spent mostly on health care services. Mostly they spend money on curing patients through polyclinics and primary care. But we do not have financial resources for the development of, for instance, evidence-based practice within prevention. We cannot expect money from government for this issue. By adopting a strategy, we hope that international organizations such as WHO, UNICEF and other organizations would provide more contributions (representative, Mother and Child Health, Ministry of Health).

National funds are spent on health *care*, so health promotion and disease prevention are put aside and remain without significant financial resources. The lack of government finance is also linked to the low salaries of health professionals and consequently to the existence of informal payments within the health system. The problem of informal payments by patients to health professionals was brought up by all actors as a central issue that substantially worsens access to the health system and increases inequities among population groups, although some emphasized that the phenomenon is not as serious within child health as it is within other health areas. Informal payments create a vicious circle of low salaries augmented by informal payments and poor health-seeking behaviour. Consequently, this informal flow of resources was perceived to be standing in the way of successful strategy implementation.

Health services

One of the main challenges within the Armenian health system is how to ensure the supply of well-trained health professionals in all geographical areas of the country. Stakeholders claimed that there is no motivation for health professionals to work in remote areas of the country. Because of the scarcity of resources, it is difficult to create positive motivational factors such as good salaries and better infrastructure. Consequently, health professionals are not willing to work in these areas, and remain in the cities. It was stressed that the national strategy cannot solve this problem by itself; it needs a fundamental change within the system as part of government planning.

Evaluation mechanisms should be in place as part of efforts to address health service challenges, and the strategy should contribute to this. Another way that the strategy could contribute to the quality of health services is by promoting evidence-based practice, thereby creating a base of new programmes and activities that are proven to work in the Armenian context. Financial resources for developing and studying best practice are very limited, so professionals and decision-makers rely on international organizations to provide information to support the development of evidence-based practice. It was stated that health professionals' knowledge of their specialty is not being updated. Access to information is low and preparedness for keeping themselves informed is weak, meaning that many health professionals base their work on outdated knowledge.

Actors claimed that there is a lack of resources to motivate health professionals and a lack of standardized guidelines and best practices within child health care. They also stated that there was a need to monitor and evaluate performance and coverage within the health system. The problem with monitoring and evaluation, however, is that reports from health professionals are not always reliable due to the fear of a negative report earning a reprimand from superiors. Monitoring processes should not be run by fear, but by the will to monitor reliably and the aspiration of achieving valid results.

Information systems

Actors stated that there are no mechanisms for collecting and disaggregating the data needed within child and adolescent health and development. Several surveys have been completed, but they are insufficient; a unified approach to the collection of data is not being created. Data on adolescents are particularly rare, although Armenia is now a member of the Health Behaviour in School-aged Children (HBSC) study. There are many different sources of data, but official data are not perceived as being reliable.

Consideration is needed of the type, use and coordination of data required to meet the present needs of planning and decision-making. According to many stakeholders, one of the main purposes of data is that they should increase the information flow between civil society and decision-makers. Information collection should therefore be based on consideration of how to strengthen links between different stakeholders. Coordination mechanisms between different international standards and tools that are continuously offered as directions for the collection of information should also be in place. For example, the WHO information tool accompanying the European Strategy should be streamlined with the rest of the materials and the planning of the Ministry of Health and international agencies like the World Bank. Stakeholders identified the Ministry of Health as the leader in this process; international agencies should coordinate with each other according to planning within the Ministry.

Declarations and conventions

Stakeholders stated that the strategy is in line with both the MDGs and the CRC. While there seemed to be common agreement among the stakeholders of the desirability of the strategy being based on the MDGs and CRC, it was also stressed that it was not necessary to address them in detail. It is sufficient to ensure that the content of the strategy respects the principles and that the strategy contributes to their further achievement.

Other considerations

A common strategy

There seemed to be a common understanding among most of the interviewed actors that the strategy should be developed and adopted at national level, should be closely related to an action plan, and should have the primary function of providing a common reference document that guides all involved agencies. Actors stressed that the strategy should be process oriented and be sufficiently comprehensive to ensure that modification is not required.

The development of the document seems to be progressing slowly. Stakeholders described the process as being rich in skilled people, ideas and thoughts. The development of the document, however, is not an easy task. Actors described how strategy development should progress in accordance with a broad point of view, be based on as much experience as possible, reflect all perspectives and involve and motivate all relevant stakeholders. Numerous factors therefore need to be taken into account before and during its formulation. It was also recognized that the inclusion of different perspectives may lead to slow progress in strategy development.

Armenian society developing at different paces

Several stakeholders stated that health is not perceived as a central value among the Armenian population. It was pointed out that health is not only the responsibility of health professionals and of the Ministry of Health, but also of the entire society. The reason for the lack of attention towards health in society seems to be that the public health discipline is a recent arrival on the Armenia scene and is not yet widely influencing the practice of health professionals.

Actors stated that there is a gap between the public health understandings of younger and older health professionals. Armenia is facing great societal transformation in which new knowledge and new understandings within health are changing ways of working at different paces, depending on the age, openness and changeability of different institutions and individuals. According to discussions at a roundtable, strategy development is based on an assumption that the concept of public health is already widely accepted and incorporated into ways of working within the country, but there is a mismatch between the basic tenets of the strategy and the attitudes and values of older health professionals within the country.

Summary of the Armenian case study

Armenia was selected as one of the pilot countries for the assessment of the draft European Strategy and of its tools in 2004. A strong collaboration was set up with the Regional Office with regard to the pilot process.

The country has prepared a draft national strategy and is approaching the initial stage of implementation. The process started in 2006, guided by the Ministry of Health through the Institute of Child and Adolescent Health, and is being conducted in collaboration with, and with the support of, the Regional Office and the WHO Country Office in Armenia. The main anticipated next steps are the formal approval of the strategy document after its finalization (monitoring mechanisms, gender and environmental issues should be integrated by this stage), initiation of the implementation phase and monitoring and evaluation of the process.

Armenia received financial support from different international, bilateral and nongovernmental organizations to support development of activities in the field of child and adolescent health and development. In particular, the Regional Office financially supported the organization of the national workshop on child and adolescent health and development held in November 2006 and the participation of national representatives in workshops throughout the WHO European Region. The Regional Office also provided continuous technical support, especially through country missions and by supervising the drafting of the national strategy. Armenia expects further technical support from the Regional Office in preparing a monitoring tool, which would be helpful in assessing progress made in implementation, a costing tool for planning implementation and service delivery and a tool for incorporating the strategy's principles and values into undergraduate and postgraduate curricula.

Armenia used experiences gleaned from other countries in developing and introducing policies and programmes in specific fields of child and adolescent health and development and conducted a number of long-term collaboration activities with partners including Switzerland, Belgium, France, the Russian Federation, Germany, the United States and Canada. The draft national strategy refers to these experiences of international collaboration, which are reflected in existing policies. The draft of the Hungarian strategy was also considered in the preparation of the Armenian draft document.

In analysing influencing factors of the national process in Armenia, the main barriers found were lack of intersectoral collaboration, lack of financial and human resources (availability of the relevant staff to participate in the process and of educated and younger staff working in the field of maternal and child health), and the fact that child and adolescent health is not always considered a priority in ongoing reform processes. Also, legislation on some specific items was considered controversial by national contributors to the Armenian case study. On the other hand, support from the Regional Office, the political commitment of the Armenian Parliament, Government and some local authorities and the active involvement of partners working in the field of child health were mentioned as positive influencing factors.

Political commitment seems to come in two parts: one part is on paper, and the other part is in action. Actors believed that the promise extolled in the former is often not realized in the latter. There is a common understanding among the actors – including decision-makers – which the “action” commitment is conspicuously absent, while the positive attitude and stated priorities are clearly present. Despite an unstable political environment, one key political person seems to create some kind of stability and predictability in the process. This encourages stakeholders believe that the strategy will be implemented.

Stakeholders agreed that youth participation would be beneficial in decision-making processes related to child and adolescent health and development, but youth participation was practically non-existent in the development of the national strategy. Technical support in this regard should be sought from NGOs. NGO representatives stated that the biggest problem in relation to youth participation is the fact that representatives tend to come from higher social strata and are not necessarily representative of young people as a whole. Despite the fact that NGOs are directly involved in the development of the strategy and are regarded as a good “entry point” to the involvement of the general population, they merely provide sporadic advice.

With regard to the life-course approach, it was pointed out that adolescent health is not being given due attention in Armenia. The needs of other age groups are not reflected in different policies or in practice as primary health care services change from being provided by paediatricians to being provided by general practitioners.

Mental health was highlighted as the area in which inequity is most obvious, but socioeconomic factors in general are causing inequities in other health sectors in Armenia. Addressing inequity issues in the strategy would draw attention to existing inequities in the country. The gender issue is regarded as a weak point of the drafted strategy, which is partly related to cultural factors: frequently, “gender” is understood to relate to women’s rights. Also, a lack of disaggregated data by gender is presenting problems in trying to incorporate the gender perspective into decision-making.

Different sectors in Armenia tend to work rather “vertically”. Each ministry seems to be controlled by an individual set of interests and values. To enhance interaction between the sectors, there needs to be a systematic approach that clearly defines the work tasks of each.

One of the main challenges identified was setting priorities within child and adolescent health in accordance with the needs of the population by taking into account both the extensive information from experts and the available grants and interests of donors.

The health budget in Armenia is increasing, but there is a tendency to use financial resources on health care instead of health promotion. There is also an extensive flow of informal payments within the health system, which naturally affects access to health services.

Health professionals are concentrated in the urban areas of Armenia and it is extremely challenging to motivate people to work in rural areas. Stakeholders claim that there is a lack of resources to motivate health professionals and call for standardized guidelines and best practice guidance within child health care. Finally, stakeholders hope to be able to carry out more qualified monitoring and evaluation of performance and coverage within the health system.

Regarding the collection and analysis of child and adolescent health data, there seems to be extensive over-reporting within the Armenian health system. Stakeholders stressed the need for a unified system of data collection to create a link between the needs of the population and decision-making. This unified approach would also require a streamlining of existing data collection tools.

Actors agreed that the strategy draft is in line with both the MDGs and the CRC. It was pointed out that there is no need to integrate declarations and conventions in an explicit way, as long as the strategy follows their principles.

It was reported that the main challenge for Armenian strategy development and implementation is making the document a core reference source for all relevant stakeholders. The development process has been going quite slowly and needs to be speeded up to take advantage of a favourable political situation. Key challenges listed for the implementation process are the establishment of good intersectoral collaboration mechanisms, the identification of comprehensive and targeted future goals and the definition of feasible and realistic steps for strategy implementation. From the financial point of view, there is a need to assure coverage of future implementation activities.

In general, Armenian society is slowly becoming acquainted with the principles and values of public health; it is a long process, but the strategy greatly depends on it, since it is built on public health principles.

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Case study – Hungary

Background information on Hungary

Hungary is located in the Carpathian basin in central Europe. It is an industrialized country and its performance in relation to health and other demographic and socioeconomic trends can justifiably be compared with other industrialized nations, particularly those in Europe. This is an important consideration in explaining the nature of Hungary's relationship with, and support received from, international organizations: as an industrialized nation, the nature of the support is different from that received by other, nonindustrialized case study countries.

Hungary had an estimated population of 10 million in 2003, with almost 65% living in urban areas. The population has been decreasing since the 1980s, mainly due to a low birth rate and negative natural population increase. The proportion of older people (aged 65 or over) has also been increasing steadily, accompanied by a decrease in the proportion of those aged 14 years or under; the Council of Europe estimates that the latter population fell from 20% in 1990 to 16% in 2003 (1).

Using the European Union's definition of poverty,^{vii} between 10% and 15% of children aged 0–17 years belong to households with equivalent income of less than 50% of the median in Hungary, which places it in 13th position of the 24 Organisation for Economic Co-operation and Development (OECD) countries analysed (2).

Gaál (3) reports that “the health care budget [in Hungary] has shrunk considerably as a result of four years of economic recession [together with] eight years of effective cost-containment policies in the health care sector”, which directly affects the European Strategy implementation process in the country. The BCA for 2008/2009 between the Ministry of Health of Hungary and the Regional Office established different health priorities, of which “scaling up control and prevention of major noncommunicable diseases” may have a particularly positive influence on child and adolescent health and development.

Case study narrative

Overview

Initiation of the national implementation process

A senior adviser from the National Institute of Child Health, on behalf of the Hungarian Ministry of Health and the National Institute of Child Health, was invited to participate in a workshop in Copenhagen in December 2004 at which the draft European Strategy and associated tools were introduced. The National Institute of Child Health was then invited to contribute to the evaluation of the draft European Strategy.

The Ministry of Health requested the National Institute of Child Health to develop the national programme for child and adolescent health in July 2005, under the name of “Children, our common treasure”. The structure, goals and priorities of the European Strategy were well understood by the National Institute of Child Health at that time and, as a consequence, aspects

^{vii} The European Union's definition of poverty states the poor are: “those whose resources (material, cultural, and social) are so limited as to exclude them from the minimum acceptable way of life in the Member States in which they live”. As UNICEF has added, “for practical and statistical purposes, this has usually meant drawing national poverty lines at a certain percentage of national median income”.

of the European Strategy are reflected in the national programme. The goals of the national programme were defined in the summer of 2005 and it was officially launched by the Prime Minister in November of the same year. The programme relates not only to health improvement and health care services for Hungarian children, but also reflects the need for multidisciplinary and multisectoral cooperation.

Funding and resource mobilization mechanisms

The national health care budget, including health care for children and adolescents, is predominantly based on the National Health Fund regulated by the Parliament through the Finances Act. Regulations for paediatric and adult care coincide and, accordingly, the primary health and clinical care budget for children and adolescents is not separated from the general health care budget. Separated provision is available for the protection of mothers and children; this covers expenditure on the health visitor network and the budget for school health services.

The national programme had no unique budget, except for US\$ 238 095.23 for the National Institute of Child Health to support the development and implementation of certain programmes.

Ministry of Health-financed activities of the National Institute of Child Health in 2007 were the following.

- Completion of situation analyses on neonatal resuscitation practices, adolescent reproductive care, breastfeeding promotion, capacities of services providing care for children with special needs, paediatric rehabilitation and psychiatric care.
- Research activity:
 - national report of the HBSC survey carried out in 2006;
 - report of the study carried out among 3- and 5-year-old children living in very deprived areas of Hungary, which looked at the association between parental socioeconomic status and birth weight and the somatic and psychomotor development of their children;
 - report on a study carried out in paediatric departments on how factors related to the hospital environmental setting and services in departments reflect the rights and health of children, conducted in the frame of the WHO Health Promoting Hospitals (HPH) network; and
 - report of the study carried out among children living in special institutions maintained by the state welfare system (such as orphanages), which focused on reported health, health behaviour and risk behaviours.
- Guidelines on:
 - screening for hearing, vision and obesity in primary care
 - how teachers can recognize child abuse and improve first-aid skills
 - when and how parents should access emergency care.

Main actors in the development of the national strategy

The list of priorities prepared by the National Institute of Child Health was based on a complex situation analysis of child and adolescent health involving representatives of approximately 150 civil and professional organizations and governmental institutions such as the Ministry of Local Government and Regional Development, Ministry for Environmental Protection and Water

Supply, and Ministry of Social Affairs and Labour. It also involved, on the request of the Ministry of Health, public health professionals and curative and preventive services.

Building on this successful collaboration, a multidisciplinary and multisectoral advisory board was charged with providing professional and political support to the national programme. The Ministry of Health attempted to take into consideration and integrate into the programme all the suggestions collected during the process. The national programme was presented for debate to approximately 70 representatives of professional and civil organizations at a national conference on child and adolescent health and development in September 2006.

Background and national context

Introduction and dissemination of the European Strategy

The European Strategy was introduced in Hungary by the National Institute of Child Health. Following the BCA, which came into force in June 2006, the national conference referenced above was organized for September 2006. The conference was jointly funded under the terms of the BCA by WHO and the Ministry of Health via the National Institute of Child Health. Four WHO experts were among those who made presentations at the conference. Representatives of the Child and Adolescent Health Programme of the Regional Office supported the National Institute of Child Health to plan the conference. Topics discussed in the working groups were based on the principles of the European Strategy.

Main outcomes of the national conference

Participants at the national conference learned about the European Strategy and a comparative analysis between its contents and those of the national programme was carried out. Four working groups discussed and evaluated whether the national programme reflected satisfactorily the main principles and priority areas of the European Strategy.

Among the outcomes of the national conference was the identification of tasks that should be specified in action plans and an identified need for improved intersectoral collaboration, which should also be reflected in different national programmes. The conference produced the following recommendations:

- children's rights must be better expressed, represented and respected in the health care system;
- the public, children, adolescents and their parents should be involved in the processes of planning, evaluating and monitoring policies;
- tasks requiring political and professional decisions should be identified;
- goals should be clearly prioritized in accordance with the restructuring process of child health care services and the financial situation of the country;
- a coordinating body should be created to enable harmonization of the National Public Health Programme and other programmes influencing child health and to ensure realistic and ongoing collaboration between programmes; and
- tasks defined in the action plans should be divided by region according to the subsidiarity principle.

Distribution of the European Strategy document and related tools

Participants at the national conference had been sent in advance a brief summary of the European Strategy and its tools and a comparison of the national programme and the European Strategy. The original English-language version of the European Strategy and its tools were distributed at the national conference.

Existing national strategy before September 2005

A draft of the national programme was available in September 2005, although it was under consultation at that time.

The Hungarian national programme has 13 goals and each of them defines several tasks (70 in total) to offer potential solutions to the most significant problems, such as the:

- relatively high rate of premature babies that increases infant mortality rates and compromises children's quality of life;
- external causes of child mortality, mainly due to accidents;
- low reliability of morbidity data;
- present inequities in health and in access to health care from qualified practitioners for the most disadvantaged population;
- predominance of inpatient care and unnecessary hospitalization of children, which reflects a need to change the structure and functioning of child health care; and
- lack of care for adolescents with special needs.

As the programme emerged in consensus, the content of the national strategy did not change after September 2005. The national conference compared the European Strategy with the national programme, and subsequent changes to the programme were set out in the conference recommendations.

National experience of the development process

National development process up to October 2007: main actions, outcomes and international support

The main events are set out in chronological order in Box 1.

Box 1. National development process pre-October 2007

2004 Information on the European Strategy received.

2005 During the summer, invitation to comment on the draft followed by finalization of the national programme, “Children, our common treasure”. During the autumn, the Prime Minister launched the national programme, ensuring its high profile.

In the winter, an advisory board was charged with supporting the national programme and ensuring multidisciplinary and intersectoral cooperation. After two months of intensive work, it ceased to function due to changes in political priorities.

2006 A national conference on child and adolescent health and development was held, and the evaluation report of the national conference and its final recommendations were sent to:

- representatives of the Regional Office
- the Prime Ministers’ Office
- the Minister of Health
- members of the Health Committee of the Parliament
- the Committee of State Reform.

Also, a report was prepared for the Hungarian Paediatric Academy and a national conference was organized by the Hungarian Association of Medical Societies to overview progress of the national programme.

2007 The implementation process of the national programme came to a slowdown due to restructuring reform of health care services.

Use and applicability of the European Strategy tools

The action tool was used to define national programme actions necessary to address the challenges previously identified. The information tool is being used to work out child health indicators that reflect indicators developed in the frame of the CHILD project, an EU project on developing indicators for child health. The assessment tool and the gender tool have not yet been used, but their possible application will be considered in the near future.

Use of experiences from other countries

No experiences from other countries were considered.

Main lessons learnt from the national implementation process up to October 2007

There are several good initiatives and programmes in Hungary that aim to improve children's health status, but collaboration between them is usually informal and is based on personal relationships between professionals. Formal collaboration has to be established by a competent, mandated organization (such as the Ministry of Health). Instead of competing with each other, organizations and agencies should work together towards the same aims.

Means of involving parents and young people in planning, monitoring and evaluating care provided by preventive and curative health services must be established.

Priorities must be clearly ordered and should harmonize with structural changes in services and the financial capacity of the country, with special attention being paid to public health issues.

Future actions

Next steps and key challenges in the national implementation process

All the goals and actions of the national programme have strict deadlines and it has not been possible to implement several of the defined actions on schedule. The national programme does not identify coordination for the programme; consequently, it is difficult to foresee the next steps.

It seems, however, that the National Government and, in particular, the Ministry of Health are committed to the following tasks:

- significantly improving metabolic screening of neonates and screening for visual and hearing problems;
- closing the gap between disadvantaged population groups and the rest of the population and promoting the development of children with special needs;
- ensuring equal access to qualified practitioners and services and defining more precise controlling mechanisms; and
- decreasing the premature birth ratio.

International support

International evaluation of the progress made in implementing the national strategy based on the European Strategy could be a motivating factor in national policy-making.

Further comments and suggestions for the next steps of the national implementation process

Ongoing financial support for the national programme is not assured as a result of restructuring of health services. It is questionable whether the goals included in the national programme can be achieved until the health services reforms are completed.

Additional comments

Additional information on specific actions, decisions or collaborations that have proven especially important and useful for the national process

Social, health and education sectors are planning several joint actions under the National Programme against Child Poverty; it is anticipated that these will have European Union financial support.

As a result of the visit of the WHO delegation (Hungarian country visit with case study interviews and roundtable discussions), the Hungarian focal point for child and adolescent health and development was appointed and acknowledged by the Ministry of Health in November 2007. The appointment of a focal point is expected to lead to an increase in the potential for interventions.

Comments from stakeholders and organizations with regard to the national development process

Most of the stakeholders expressed interest in receiving the summary of the national conference prepared by the WHO delegation. Many of them are interested in following the process of national programme implementation.

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Analysis of interviews and roundtable discussions

Political commitment

Commitment and action

Many actors claimed that political commitment is evident in support from the Government and, in particular, the Prime Minister through numerous strategies within different portfolios. This reflects the fact that a programme such as this was much-needed in Hungary. While political commitment has been expressed verbally, however, it seems to diminish when the programme needs to be implemented:

The problem with the [political] commitment is that unfortunately, it is mainly verbal. So we do not see implementation activity, which is impossible without providing the necessary resources. The amount of money supplied is just enough for very basic work, not really for implementation (Institute of Public Health).

This quotation illustrates what many actors emphasized during interviews and roundtable discussions: there seems to be willingness to develop the programme, but with no reliable funding for the implementation phase, the commitment remains verbal, and actors agreed that verbal commitment is not enough. When action is required, political support evaporates.

Lack of commitment to action was observed by all stakeholders and several suggestions were made on how to secure ongoing political commitment throughout the implementation phase. It was stressed that the international community has an important part to play in determining how resources are used and in influencing political decision-makers. For example, data based on European standards have contributed to the development of a common understanding of where to focus the collection and use of information. Other stakeholders, however, stressed that international influences should not be the critical factor in developing and implementing the programme:

It is not certain that I agree with this need for assistance from the international community. I think that we have to sort out our own problems. If we wait for the World Health Organization or for God himself to give us, then we will have great problems (roundtable 2).

Varying opinions were therefore expressed about the impact and level of influence of the international community, but the majority of stakeholders expressed positive attitudes about international assistance as long as international standards are adapted to Hungarian needs and circumstances.

Responsibilities and tasks

The national programme “Children, our common treasure” was prepared on the basis of consensus between the Government and Opposition. The programme was developed as a strategy with a particular focus on the health professions. Many stakeholders, however, highlighted the fact that child health is not only a responsibility for the health portfolio, but is also a general social responsibility which concerns many other sectors. It should therefore be in the interest of all parties and of society to support implementation of the programme.

A programme council was established when the programme was launched. Council meetings were held frequently during the initial phase, but due to changes in political priorities, the activities of the council were run down.

The relationship between the Government and civil society was emphasized as an important factor in defining the roles of NGOs in implementation. The private sector was identified as an important stakeholder in the process; inclusion of the private sector creates ethical dilemmas, however, in relation to promotion of products that are not necessarily reflective of the values of the programme. Industry has sponsored some child health activities, which has created some controversy.

The influence of health reform

According to all stakeholders, ongoing health reform in Hungary is delaying implementation of the programme:

Implementation has started, but for about six months there seems to be a silence around this. It is my perception that the restructuring of the health system has consumed all energy available in central management (roundtable 2).

This is mainly due to the fact that restructuring is not being conducted strictly according to the priorities stated in the programme. Health reform continues to dominate decision-makers' attention, leaving programme implementation to actors working at grassroots level with no significant funding. There is a commonly held belief among the stakeholders that health reform is causing less attention to be paid to priorities within child health. This means that a programme that was built on extensive consensus has been put on hold because of changing political priorities.

Guiding principles

Youth participation

Several stakeholders pointed to the fact that the education sector has more experience than the health sector in promoting youth participation through the students' parliaments that have been established in Hungary. There are many different activities that aim to involve young people in discussions, but they lack coordination:

We organized small conferences for disadvantaged teenagers to discuss sport as a means of fighting against bullying at school and other problems in the school context. So we have connections with civil organizations which involve children. But there are too many isolated activities, and there is no real coordination among them in my opinion (Institute of Public Health).

Youth parliaments within the health sector are not working to the same extent as those in, for example, the education sector. A large number of NGOs represent and debate the situation of young people, but with little direct participation of young people.

One of the greatest barriers to youth participation is the fact the Ministry of Youth, Sports and Culture has recently ceased to exist. Several stakeholders consider this to be a substantial impediment to the inclusion of young people in decision-making processes in Hungary at national level.

Participation of civil society

Civil society is extremely active in Hungary and many NGOs work for children and adolescents:

Without civil society, we cannot even think about conducting these activities. When organizing programmes, there are some outstanding personalities who with their personal participation can set a good example. We take the participation of civil society seriously (representative, Ministry of Health).

There is strong cooperation between governmental bodies and civil society. Stakeholders pointed out that it is mandatory to include the opinion of technical experts, interest groups and NGOs in different planning processes. These groups were invited to comment on the draft document in the last phase of decision-making. Examples of associations that have contributed to planning activities are the Association of Hungarian Nurses and the Association of School Health. The important role of the Church was also underlined by several interviewees:

In Hungary, the special problem is that in the course of the last decade civil activity has grown tremendously and we are overdoing it a bit, actually. There are too many different organizations. Altogether there are thousands of organizations targeting the same subject. All of them want to do their utmost and at the same time they are fighting each other. So there is some counterproductivity because of this (representative, Institute of Public Health).

A large number of NGOs address similar issues, resulting in very limited resources for individual organizations. Stakeholders made two main suggestions to solve this problem: accreditation for NGOs, and joining their forces into umbrella organizations that fundraise together instead of against each other.

Life-course approach

Addressing neonatal and infant health was considered to be of outstanding importance. According to some stakeholders, however, the focus on early childhood has been achieved at the cost of lack of sufficient attention being paid to the needs of other age groups. All stakeholders agreed that adolescents are the age group that receives least attention by far, particularly considering the special guidance and care needed by young people going through adolescence. Adolescent clinics have been established to provide specialized services to young people to try to redress the imbalance, and this will hopefully contribute to an increased recognition of adolescents' particular problems.

Equity

Inequities in Hungary are characterized as being mainly caused by territorial differences and differences between different population groups; the Roma population, for instance, have very different traditions and behaviours than the rest of the population. These two features seem to go together: the Roma population often live in very isolated areas where access to health care is limited and are identified as a population group with social problems that have remained unsolved in Hungary for decades.

Cultural and traditional issues affecting the health status of the Roma population are defined as being difficult to address because inequities are often perceived as being caused by poverty instead of cultural factors:

And there is a kind of tension on this matter: how to interpret social inequalities, whether it is merely a financial issue, or can we consider this as a cultural issue as well? (roundtable 2).

Integration into the community, starting through education, is crucial in improving the health status of the Roma population, but addressing this group separately according to cultural differences is regarded as highly problematic. Collecting data specifically on the Roma population is therefore also a sensitive issue, which makes it difficult to address their health behaviour.

Intersectoral action

There seems to be close collaboration between the Ministry of Education and Ministry of Health, with different programmes within health being integrated into education programmes and vice versa. Intersectoral coordination has been established, especially in relation to projects funded by the European Union. In addition, the Ministry of Social Affairs is collaborating to a large extent over, for example, drug prevention.

Despite this, competition over financial resources between different ministries was identified as a barrier to intersectoral action:

We [the sectors] tend to compete with each other all the time. The question has been asked, what responsibilities will be held by the portfolio of health and the portfolio of education and what kind of role can the portfolio of education have in implementation of the programme in schools? This has not been clear (roundtable 1).

Different sectors are competing, and there also seemed to be significant doubts about their specific roles and responsibilities within the area of health promotion.

Improving health systems

Stewardship

Priorities within the Hungarian programme for child and adolescent health and development are based on a situation analysis and are divided according to the life-course approach, meaning that different priorities apply to different age groups.

Difficulties professionals faced in setting programme priorities were mainly related to a lack of reliable data, with the exception of data on demographic issues. For example, there was scarce information on what was going on in neonatal intensive care centres; this resulted in the creation of a new data collection system within intensive care centres and at primary health care level. The latter should provide more information on children accessing services from general practitioners and paediatricians.

Financing

Scarcity of financial resources for health was identified in all disciplines and all professional alliances. The means of allocating financial resources was also considered a problem.

Most stakeholders believed that the solution to the funding scarcity is not to be found within the Government, but should be sought elsewhere. More specifically, project-oriented financing is considered a means to creating the necessary resources for child and adolescent health. Resources from the European Union compensate for the scarcity of national financial resources for child health to a large extent, but this may affect the sustainability of the national programme.

Health services

Ongoing health reforms in Hungary greatly affect the quality of, and access to, health care for children and adolescents. Due to the closure or merger of several hospitals and clinics, more and more children will be cared for in hospitals that have no specialist paediatric service. Many children will consequently receive care from services designed for adults. Intensive care and rehabilitation – the areas identified as the least-well financed in health care – are also the areas where quality is questioned by several stakeholders.

Many people who participated in the development of the national programme for child and adolescent health and development hoped the health reforms would be no more than a quick fine-tuning that would result in new configurations in inpatient and outpatient care for children. It was recommended that this should be more clearly organized to prevent a severe crisis in child health care.

Information systems

Accessibility of child and adolescent health data is described as rather good, with the HBSC study being identified as an extremely important source of information. In general, there seems to be strong collaboration between the institutes that collect relevant data and political decision-makers.

The quality of data collected was nevertheless questioned by several stakeholders. In particular, stakeholders referred to the fact that there is no clear definition of indicators of data collection, nor of who should collect the data and how they should be collected. Coordination is required to streamline the data and ensure that collection and validation is carried out in an effective way without slowing down the process. In particular, relevant institutes should be included in the process from the beginning to ensure proper definition of indicators.

There seems to be a major problem in the reliability of data on minority groups; all stakeholders agreed that this is an issue that needs to be addressed in the future.

Declarations and conventions

Children's rights are not mentioned explicitly in the national programme, and it seems that attention to, and respect for, children's rights is lacking to a large extent in the health sector. A national survey on children's rights in hospitals confirms this.

One of the recommendations sent to the Ministry of Health from the national child conference held in September 2006 was related to the lack of respect shown to children's rights in hospitals and in the health sector as a whole. A proposal was made to introduce an ombudsman on children's rights in Hungary, but without success. The capacity of health professionals to incorporate the CRC into their daily work should be increased.

The MDGs are not widely known in Hungary: most stakeholders stated that the goals were not integrated in the national strategy.

Other considerations

Health promotion is a central value of the European Strategy, but stakeholders claimed that health promotion is still not an underpinning consideration within the health sector or within the general population in Hungary. There does not seem to be a clear understanding of health promotion as being fundamental to a national programme of child and adolescent health in Hungary. This is reflected in the goals set out in the current programme: of 13 goals, 12 deal with issues that are specific to health care. The programme deals with health promotion in a different way, referring to health promoting projects of sectors working with social and education affairs.

The programme is therefore "vertical" and is restricted to health care, but aspires to be crosscutting by referring to other activities. This seems to be a deliberate decision made by the developers of the strategy and reflects financial restrictions. It nevertheless causes ongoing debates about the role of public health within the programme and how it is valued. It is important to emphasize, however, that despite great political debate on the programme, there seems to be a common understanding in Hungary that it is built on consensus among stakeholders:

There is always a debate about the programme. It is a political debate between the stakeholders and between the state and civil partners whether the programme should be vertical. But this programme is a result of consensus (Ministry of Education).

There is a prevailing consensus among stakeholders that people largely accept and believe in the content of the programme. Stakeholders state that the intentions and analysis of the programme and the involvement of interested parties are perceived as being adequate and are viewed very positively. In general, different actors stated that common interests determined the development and implementation of the programme and that there are no significant tensions between the agendas of the different stakeholders. Despite this, implementation has slowed down due to lack of technical and financial coordination and the health reforms, which seems to bring many child and adolescent health activities to a stop.

Some actors considered the four-year political cycle to be the main barrier to programme implementation. Implementation of many programmes ceases while actors wait for a new cycle to begin, because anticipated political changes are expected to drive fundamental changes within each sector.

Several stakeholders emphasized the need for a clear financial structure for the implementation process to reactivate the programme. This would ensure that the implementation plan was realistic and could be directly sustained over a longer period of time. Without a clear statement of budgetary allocations from each sector, the sustainability of the programme is fragile.

Implementation of the programme is currently continuing at local level, but local stakeholders tend not to perceive their activity as part of the national programme. Professionals are therefore being left alone to a large extent in implementing small parts of the programme with neither funding nor guidance.

It is obvious to all stakeholders that health problems within different countries cannot be handled in a uniform way and that the strategy has to be tailored to the specific needs of the population. Several stakeholders emphasized the need for adapting the European Strategy to the Hungarian situation and the special contextual factors of the country:

There is an old general thing, which is good for any country. Every country needs to recognize its own needs and its own history, and its own way of handling things. We always come to the conclusion that every country has to decide for itself (Institute of Public Health).

Summary of the Hungarian case study

This small country in central Europe was one of the pilot countries selected in 2004 for the assessment of the draft European Strategy and related tools, resulting in strong collaboration with the Regional Office.

Hungary has developed a national child and adolescent health and development strategy inspired by the draft European Strategy. It was officially launched by the Prime Minister in November 2005. The national conference in September 2006 created an opportunity for national experts, stakeholders and Regional Office representatives to compare the contents of the national strategy document to the European Strategy.

The final outcome of this workshop was a report with specific recommendations on how to improve the national strategy by addressing existing gaps, such as the unsatisfactory level of acknowledgement of children's rights in health care and lack of participation of children and adolescents in strategy development and implementation. Recommendations also focused on: prioritizing strategy goals in a compatible way with the health care reform restrictions; harmonization of the strategy with other programmes influencing child health; and the clear definition and distribution of tasks among sectors and between national and regional-level authorities. Hungary is currently implementing the national strategy, although the process slowed down in 2007 due to the ongoing health system reforms.

Hungary is an industrialized country, which is an important determining factor in relation to the nature of support received from international organizations. The case study narrative only mentions the role of the Regional Office in terms of technical support offered and its financial contribution to developing the national workshop, which was partly financed by the Hungarian Ministry of Health. These activities were carried out under the terms of the previous BCA. With regard to Hungary's future expectations, European Union funds should play an increasingly important role: social, health and education sectors are planning several joint actions under the national programme against child poverty which are expected to receive European Union funding.

The National Institute of Child Health was mandated by the Ministry of Health to introduce the European Strategy in Hungary. The European Strategy and its tools were distributed through the national workshop. The action tool was used to define national programme actions in response to the main challenges for child and adolescent health and development, and the information tool is being used to develop indicators. The applicability of the evaluation and gender tools in the national process is currently being reviewed.

Among the main difficulties encountered was the slowing down of the national implementation process in 2007 due to the ongoing health system reforms and consequent structural problems, such as the lack of a unified budgetary allocation. Other barriers included difficulties in coordination mechanisms (the advisory board is no longer functioning and intersectoral collaboration is mainly based on informal relations).

Enabling factors include the expertise, enthusiasm and efforts of professionals and scientific organizations working in child health care and results achieved by the National Institute of Child Health, the Institute of Health Promotion and the Institute of Nutrition and Food Safety, although there is not a clearly defined and institutionalized operational context. The Ministry of Health has recently formally designated a child and adolescent health and development focal point at the National Institute of Child Health as an outcome of the Regional Office country visit in November 2007. Regional Office supervision and evaluation is considered a motivating factor for the national implementation process.

Many actors claimed that there is political commitment in Hungary, as the national programme is supported by the Government and was officially launched by the Prime Minister. Stakeholders stated, however, that although verbal commitment has been expressed through numerous strategies from different ministries, political support often evaporates when action is required. The question seems to be about how to ensure political commitment throughout the implementation phase: interviewees and participants of the roundtable discussion made several suggestions in this regard.

The national strategy in Hungary has a significant focus on health professions, but stakeholders agreed that child and adolescent health is a general societal responsibility. There was a common understanding among stakeholders that the ongoing health reforms draw attention from child and adolescent health priorities.

In relation to youth participation, most of the actors claimed that the education sector has more experience than the health sector, as students' parliaments have been established. A large number of NGOs within the health sector represent young people and debate issues relevant to them, but there is little direct youth participation. Civil society was reported as being extremely active in the country in the area of child and adolescent health.

The life-course approach is considered to be of significant importance in helping to address neonatal and infant health, but there is a lack of attention on other age groups as a consequence. Stakeholders agree that adolescents are the age group that receives least attention by far and, in response to this problem, adolescent clinics have now been established.

Inequities in Hungary are mainly caused by territorial differences and by differences between population groups, particularly relating to the Roma population.

Stakeholders stated that there is close collaboration between the Ministry of Education and Ministry of Health, with health programmes being integrated within education programmes and vice versa. The Ministry of Social Affairs is also collaborating on issues such as drug prevention. It was mentioned that intersectoral collaboration is specifically important when projects are funded by the European Union. The different sectors are not competing, but there seems to be doubts about clear definitions of roles and responsibilities in the area of health promotion.

Most stakeholders perceived financial resources as being scarce in comparison to the resources allocated to health in other European countries. This was highlighted within all disciplines and in all professional alliances. Stakeholders identified the main problem as being how resources are allocated and believed the solution is to fund additional resources outside of the government. Resources from the European Union compensate to a large extent for the scarcity and inefficient means of allocation of national resources.

Ongoing health reforms, as mentioned above, are greatly affecting the quality of, and access to, health care services for children and adolescents.

The accessibility of child and adolescent health data is described as good and there seems to be strong collaboration between the institutes that collect data and relevant political decision-makers. The quality of collected data, however, apart from data on demographic issues, was questioned by several stakeholders who expressed concerns about the unclear definition of indicators and lack of clarity on responsibilities for data collection. The main problem identified was the reliability of data on minority groups.

Stakeholders stated that attention to, and respect for, children's rights in the health sector is lacking to a large extent, as was confirmed by the results of a national survey on children's rights in hospitals. One of the recommendations of the national conference was related to this issue. The MDGs are not widely known in Hungary.

The key challenge in Hungary is to respond to the different recommendations set out in the final report of the national workshop. These address the need for improvement in: coordination

mechanisms of the national process; youth and civil-sphere participation; the division of tasks between sectors and national and regional authorities; and the abovementioned issue of assuring more respect for children's rights in the health sector.

Since implementation has come to a standstill, one of the most important tasks is to reactivate programme implementation. It is a great asset that people seem to believe in the content of the programme. This motivation can encourage stakeholders to take the programme forward. It is vital that actors carrying out the tasks defined by the programme are not left alone with the responsibility. Evaluation and follow-up on this work is therefore essential in creating awareness and ownership of the programme.

Finally, the challenge of including health promotion in the programme and ensuring that it is not only health care oriented could be met by referring extensively to other crosscutting activities and other sectors and involving them in activity planning. This might create debate on public health issues and thereby increase knowledge in the area.

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Case study – United Kingdom (Scotland)^{viii}

Background information on United Kingdom (Scotland)

United Kingdom (Scotland) (hereafter referred to as “Scotland”) is one of the four countries making up the United Kingdom. It is a small country with a diverse geography and history. The majority of the approximately five million population live in the major towns and cities, particularly the “central belt” – the area of lowland Scotland stretching from the Clyde coast in the west through Glasgow and to Edinburgh in the east. A significant proportion, however, live in the many remote and rural areas found across the Highlands and Islands.

Many periods of migration have shaped the population today. Migration from and within Scotland has been largely economically driven, with many leaving Scotland altogether during the Highland clearances or moving to the industrial areas of the central belt. The north west is traditionally the area where Gaelic is spoken, and there is a strong Celtic tradition. The east of the country has been heavily influenced by ancient Scandinavian invasion and migration. There has been movement between Scotland and Ireland over many centuries, most significantly with a massive influx of Irish immigrants during the 1840s, especially to Glasgow. Many other migrants have settled since then – Italians in the late nineteenth and early 20th centuries, followed by Chinese and many from the Indian subcontinent. Now in the early 21st century, there is immigration from the former Soviet bloc, particularly Poland, alongside refugees and asylum seekers from many other countries. As a result, there are currently over 40 languages spoken in Scotland.

Like many small countries with a large neighbour, Scotland’s relationship with England has not always run smoothly, although there was an eventual union of the parliaments in 1707. Scotland has retained its own legal, education, religious and financial systems through to the present day, with the Scottish Parliament reconvened in 1999 as part of the devolution settlement within the United Kingdom. The Parliament has responsibility for health (among other things).

There has been considerable research and debate about the poor health of Scotland compared to the rest of the United Kingdom and other parts of western Europe. Trends show that the rates of improvement in Scotland are similar to that elsewhere in the United Kingdom, but the actual prevalences of poor health remain higher in Scotland. The average figures mask major inequalities. More-affluent Scots enjoy good health, unlike those in the country’s many disadvantaged areas, particularly in the west of Scotland, as was recently demonstrated by the WHO report on the social determinants of health (1). Similarly, an OECD review of education (2) indicated many strengths in state-provided education, but noted major problems for those from less-affluent backgrounds that became more marked during secondary education.

The poor health of sections of the population, especially in more economically disadvantaged areas, has been of concern for many years, and indeed was probably first noted by city medical officers of health in the 19th century. Numerous attempts have been made to change the situation, often by physical regeneration with major housing developments between the World Wars and, less successfully, in the 1960s. More broadly based regeneration partnership and policy drivers continue today, but inequalities in health outcomes persist, with concerns that they are increasing for some conditions and parts of the population. A number of factors have been

^{viii} United Kingdom (Scotland) does not have a separate strategy for child and adolescent health, but has used the European Strategy action tool to create a framework for children in the country.

put forward to explain whether the continuing problems are due to a “Scottish effect”, as it would appear that they cannot be explained by health behaviours (such as smoking rates) or poverty alone. Such explanations range from the major impact of deindustrialisation, to specific population movements and employment patterns, through to the effect of latitude and climate on vitamin D levels.

Whatever the explanations, health policy in Scotland is currently strongly focused on inequalities. As will be apparent in this case study, recent policy demonstrates an increasing emphasis on the importance of health in childhood and adolescence.

Case study narrative

Overview

Initiation of the national implementation process

The use of the European Strategy in Scotland was initiated by the Children and Young People’s Health Support Group (CYPHSG), which advises health ministers. The group had consulted on a proposed action plan for children and young people’s health in early 2006 and the response indicated the need to strengthen the health improvement content of the plans. CYPHSG set up a subgroup to review health improvement policy and action and approved the use of the European Strategy framework and tools for this purpose.

Funding and resource mobilization mechanisms

Government funding for the National Health Service (NHS) in Scotland is decided at the time of spending reviews carried out across government every three years. The total allocation of funding is therefore a top-level political decision based on information provided by government departments on historic spend and future needs. The allocation is then refined in an annual budget which reflects the costs of existing services, developments required by policy, issues resulting from staff pay negotiations and any efficiency savings required across government.

A formula based on demographics and deprivation is used to calculate the annual allocation of funding to the 14 territorial health boards and 5 special health boards in Scotland who deliver services. These boards are accountable to the Cabinet Secretary for Health and Wellbeing through the Chief Executive of NHS Scotland for the delivery of services and the achievement of national targets on health, efficiency, access and treatment (HEAT targets). The current targets include breastfeeding, healthy weight in children and child oral health.

Main actors in the development of the national strategy

Education is the lead sector for children and young people, with the Scottish Government Education Directorate being responsible for involving colleagues from other departments and external agencies in developing strategy for children and young people. The policy direction is set by the strategy *Getting it right for every child* (3). The post of a Minister for Early Years was created in 2007 within the team of the Cabinet Secretary for Education, Children and Lifelong Learning.

The CYPHSG has a role in advising health ministers. Subgroups are set up for specific purposes, and these may co-opt members. Group membership is mainly drawn from the health sector, but with participation from other sectors. Membership has expanded in the last few years to include a wider cross-section of representatives who are recruited by nomination from their national body or professional organization.

Background and national context

The structures and policies that make up child and adolescent health strategy in Scotland derive from the foundation of the NHS 60 years ago. Provided through taxation, the service was intended to be free at point of need and promoting health was seen as a key aim. Despite many changes and developments, these fundamental principles remain and are strongly supported by the general public.

The existence over 60 years of a health care system funded by taxation means that many things are taken for granted and accepted as the “norm” in Scotland. Examples include the use of obstetric services and universal immunization programmes with high rates of uptake, access to free consultations with primary care services and professionals such as general practitioners, and immediate access to helplines and accident and emergency services.

Following devolution and the re-establishment of a Scottish Parliament in 1999, health policy has been a key responsibility of government in Scotland, although there are joint committees across the four United Kingdom home countries on issues such as immunization and screening.

Delivering a healthy future: an action framework for children and young people’s health (4) (hereafter referred to as the Action Framework) was published in 2007 as the action plan for health services. National health policy was defined in 2007 in *Better health, better care: action plan (5)*, which has a strong emphasis on children and young people under the theme of “best possible start”. Most recently (spring 2008), legislation that sets nutritional standards for schools has been passed, embedding health promoting schools in legislation. Current developments include the proposals for an Early Years Framework and the development of a Ministerial Task Force on Inequalities in Health, both of which will report in 2008.

Following the change of government in 2007, government departments, including health, have been restructured. A concordat was signed in 2007 between central and local government with agreed national outcomes (for children and adolescents these are that: our children have the best start in life and are ready to succeed; our young people are successful learners, confident individuals, effective contributors and responsible citizens; and we improve the life chances of children, young people and families at risk). All local authorities now have individual single-outcome agreements with central government using indicators that demonstrate national outcomes. This represents a major change in the mechanisms of government in Scotland.

Introduction and dissemination of the European Strategy

As the national agency for improving health in Scotland, NHS Health Scotland has long-standing links with WHO. It has had collaborating centre status with WHO over many years, initially developing from health promoting schools work. It also hosts the coordination of the WHO Health Promoting Hospitals (HPH) initiative in Scotland and supports the Royal Hospital for Sick Children in Edinburgh as a “hub” paediatric hospital to represent Scotland on the HPH Child and Adolescent Health Task Force. The health improvement representative on CYPHSG is from NHS Health Scotland. As a result of these links, NHS Health Scotland was aware of the European Strategy and proposed its use to review health improvement aspects of the Action Framework in Scotland (4).

Main outcomes of the national workshop

No national or local workshops or training courses have been organized specifically on the European Strategy, but workshops have taken place on, for example, developing the national delivery plan for specialist services for children and young people (6).

Distribution of the European Strategy document and related tools

The European Strategy has been distributed in Scotland through the HPH “hub” paediatric hospital. NHS Health Scotland, as a WHO collaborating centre, hosts the HPH coordination and has a representative on the CYPHSG.

Description of existing national strategy before September 2005

There was no child and adolescent health strategy as such prior to 2005, but many components were in place either within education or health policy, and these could be interpreted as constituting a national strategy.

Policy in 2005 derived from the education department document *For Scotland's children* (7), which identifies the need to:

- consider children's services as a single-service system
- establish a joint children's service plan
- ensure inclusive access to universal services
- coordinate needs assessment
- coordinate intervention
- target services.

Health for all children (8) (known as Hall 4) is a United Kingdom-wide evidence-based framework for the assessment, support and monitoring of children's health from birth through to adolescence. Scottish guidance was developed in 2005 (9), which addresses the universal core programme for child health screening and surveillance. A process of review of the implementation is now underway, reporting to CYPHSG. Key to this is the national information databases covering the child health surveillance programme within Hall 4.

The broader children and young people's agenda has developed at national level under the former Scottish Executive's Children and Young People Delivery Group, a cross-government group of ministers. This led to two key strands of policy: *Getting it right for every child* (3) and the Action Framework (4).

The education-led multi-agency strategy *Getting it right for every child* (3) lays out the principles for putting the child at the centre of education by:

- providing a focus on improving outcomes for children, young people and their families based on a shared understanding of well-being;
- creating an integral role for children, young people and families and those with a relevant interest in reaching the decisions that affect children's lives as part of assessment, planning and intervention;
- maximizing the skilled workforce within universal services to address concerns at the earliest point possible, bringing others around them as needed;

- developing a common approach to gaining consent and sharing information where appropriate;
- developing a coordinated and unified approach to identifying concerns, assessing needs, agreeing actions and outcomes based on indicators of well-being;
- streamlining planning, assessment and decision-making processes to enable children to access the right help at the right time;
- developing high standards of cooperation, joint working and communication when more than one agency needs to be involved;
- developing a confident and competent workforce in the statutory universal and targeted services and in the independent sector;
- appointing a lead professional to coordinate and monitor multiagency activity where necessary; and
- creating the capacity to share demographic, assessment, planning and outcome information electronically within and across agency boundaries through the national eCare programme, where appropriate

Key to this work is the protection of children and developing single shared assessments and plans for children which bring together relevant agencies across all sectors. A number of pathfinder sites are being supported across Scotland to develop tool kits, protocols and good practice. There is active communication across Scotland on these developments with regional roadshows and a regular newsletter.

The Action Framework (4) was developed by CYPHSG during 2005/2006. It sets out a comprehensive series of actions that mainly focus on the delivery of health services, and covers:

- provision of local care
- emergency care
- hospital services
- specialist services (now part of a further review (6))
- child and adolescent mental health
- children with complex needs
- remote and rural care.

This document acknowledged its own limitations in taking forward the health improvement agenda for children and young people, and these were confirmed by responses to the consultation in summer 2006.

National experiences of the development process

National development process up to October 2007: main actions, outcomes and international support

In support of its desire to ensure a coordinated and comprehensive approach to children and young people's health, the CYPHSG established a working group in November 2006 to make recommendations by March 2007 on the priorities for health improvement for children and young people. The working group took a broad approach in its interpretation of improving children and young people's health.

The key tasks of the working group were to:

- consider health improvement issues raised in response to the Action Framework to inform a mapping of policies relevant for children and young people's health improvement;
- map key policy streams and initiatives relevant to the health improvement of children and young people (and identify any gaps);
- use the European Strategy and its related tools to facilitate this process; and
- make recommendations on priorities to the CYPHSG in March 2007 and report on the process to WHO.

The membership of the working group reflected the breadth of health determinants (and therefore interests relevant for health improvement). Members were predominantly drawn from the CYPHSG but also included individuals with relevant expertise, particularly in health improvement and mental health.

The mapping exercise taken forward by the working group showed that Scotland has clear areas of strength in all seven priority areas defined in the European Strategy action tool (Box 2).

Box 2. Performance in Scotland against action tool priority areas

Priority area 1, Mother and Neonates Scotland meets the standards outlined in the action tool and is in a strong position.

Priority area 2, Nutrition; Priority area 3, Communicable Diseases; Priority area 6, Injuries and Violence Hall 4 provides an integrated and effective policy context for children and young people's health covering these priority areas. Under the "Nutrition" priority area, the *Action plan for improving oral health and modernising NHS dental services in Scotland (10)* was identified as providing clear direction and resources. Scotland meets all the recommendations outlined under Priority 3, "Communicable Diseases", which includes immunization, surveillance and management of the most common infant and child infectious diseases

Priority area 4, Physical Environment Scotland demonstrates a comprehensive legal and policy framework that meets the recommended actions.

Priority area 5, Adolescent Health; Priority area 7, Psychosocial Development and Mental Health Recent policy developments such as *Getting it right for every child (3)* and *Curriculum for excellence (11)*, a major review of the school curriculum for ages 3–18, were identified in the mapping exercise as important foundations for future developments in these areas.

Priority area 6, Injuries and Violence A range of acts such as the Children's (Scotland) Act 1995, the Protection of Children (Scotland) Act 2003 and the forthcoming Protection of Vulnerable Groups Bill and Children's Services Bill will provide the necessary legislative support.

The mapping exercise also identified areas where there was a need to fill gaps and strengthen existing provision:

- infant and parental mental health was not explicitly addressed in pregnancy/newborn services, other than postnatal depression;
- a best practice review was required for preconception and pregnancy nutrition programmes;
- a healthy weight strategy was needed for children and young people;
- issues around access and equity were identified in relation to sexually transmitted infections and foetal anomaly services;
- the need for better identification and support of substance misuse in pregnancy was raised;
- an implementation strategy following the passing of the Health Promoting Schools Bill was anticipated;
- antibullying policies were perceived as not working and in need of review and development;
- disadvantaged young women were identified as accessing antenatal care late and in a limited way, and this was seen as an area requiring urgent intervention;
- primary care services need adaptation to meet the needs of young people and families with multiple problems, with the current situation being seen as contributing to poor outcomes for disadvantaged children;
- confidential and accessible services for young people are needed;
- the voluntary code on alcohol advertising was perceived as not wholly effective.

The working group's report contained recommendations on health improvement support for families, improved accessibility for, and engagement with, young people, developing life skills and resilience in children and young people, and building the capacity of those who care for them (families and professionals) to support this agenda.

The recommendations were reported back to CYPHSG and to Ministers for consideration in June 2007. This coincided with a change of Scottish Government (May 2007) which provided an opportunity to review health policy. Although there has been no formal adoption of the recommendations of the working group, it is apparent that many of the recommendations have progressed and become integrated into policy and, in some cases, practice.

Influencing factors

There has been a cultural shift in recent years in Scotland. The key factor in this is probably changes in funding for children's services following wide public consultation in the early part of the decade. Funding changes have been influential in encouraging local integration of services within local authority areas in conjunction with health boards and the development of children's service plans. These plans are perceived as having led to stronger and more coordinated services for children and have driven the creation of key professional posts in health (child health commissioners) and local authorities (children's services managers). More recently, the process has been further enhanced by the reorganization of primary health care services into community health partnerships (CHPs), with the majority covering the same geographical areas as local authorities and having an obligation to involve partner agencies, including the voluntary sector, in their work.

There have been two significant legislative changes in recent years. Scotland was the first of the four United Kingdom countries to implement legislation for smoke-free public places, a key health improvement initiative. The legislation has been well received and successfully implemented and has achieved immediate beneficial health outcomes. In addition, health promoting schools, which were already well established in Scotland, are now embedded in legislation which has a strong emphasis on nutrition and physical activity.

The general impact of these legislative changes is seen as having created a favourable climate for action to improve health. The complexity of influences on child health, however, poses a challenge, particularly in relation to broader cultural influences created by, for instance, the food industry and advertising.

Use and applicability of the European Strategy tools

The working group commented that the European Strategy and tools were very useful when undertaking their tasks.

Full use was made of the action tool in developing key areas for action and recommendations. The Health Improvement Subgroup undertook a policy mapping exercise by using the structure of the action tool and adding an additional column in which gaps could be highlighted.

The assessment and information tools were not used by the subgroup in developing recommendations, but the information tool was used for discussion during the development of the case study.

The gender tool was not available at the time the subgroup was working

An overall picture has emerged of overlapping areas of development with stakeholders accessing the same reports and research, including the European Strategy. Influences from this work are not always articulated but can be identified; they have influenced, for instance, the ongoing work plan of CYPHSG and others, which clearly support the European Strategy's key objectives.

Use of experiences from other countries

Experiences from other countries were not used by the subgroup. Subsequent discussions have suggested that this was a weakness and that Scotland has much to learn from other countries, particularly about developing a child-friendly culture and parenting.

Main lessons learnt from the national implementation process up to October 2007

Subgroup work The European Strategy was seen as setting the context and the use of the tools provided structure to focused tasks. Together, they enabled strengths and weaknesses to be identified, which influenced the formulation of recommendations. Using the tools effectively does, however, take time.

The endorsement of CYPHSG was important in ensuring the involvement of key players and use of the tools, meaning that although the recommendations were finalized at a time of political change, they have still been taken forward.

Case study process As in the subgroup work, the European Strategy was seen to have great value in the case study process. Some concern was expressed that while the European Strategy may be interesting, it might not be helpful, as it does not relate specifically to the situation in Scotland. On the whole, however, interviewees endorsed its use and the use of the CRC. Their impact was seen as being largely beneficial, although waiting for international or national developments can compromise the speed of local work.

The case study process has brought people together from a wide range of agencies and professions and enabled reflection on the broader issues surrounding child and adolescent health in Scotland. It has emphasized the importance of multidisciplinary and multisectoral work at national level in managing tensions between sectors and has both reinforced strengths and indicated weaknesses.

Individuals reflected on the impact of the case study process on themselves and noted that they had learnt the value and usefulness of working with complexity and in valuing their own contribution, which has led to increased confidence and more-effective local developments.

Working with the European Strategy reinforced the value of a coordinated life-course approach, while demonstrating the difficulty of following work through at a time of political change.

Future actions

The recommendations are relevant to several areas of current health policy, all of which have working groups which involve members of CYPHSG and the health improvement subgroup.

- *The mental health of children and young people: a framework for promotion, prevention and care (12).*
- The Ministerial Task Force on Inequalities in Health, whose report, *Equally well (13)*, places a major emphasis on the very early years and on young people.
- The action plan for the NHS, *Better health, better care (5)*, was the subject of a rapid and wide consultation in late 2007 to which CYPHSG and NHS Health Scotland fed in detailed responses. The section “Best possible start” places a strong emphasis on the early years and vulnerable groups and supports the implementation of pre-existing work.
- Policy aimed at improving poor outcomes for children and young people who have been in the care of the state (14), with a specific workstream for health and well-being.
- The development of an early years framework (15) led by the Positive Futures team within the Government Education Directorate. The lead officer for this was the education department representative on the CYPHSG Health Improvement Subgroup. Key themes in the consultation document are: parenting, community support, integrated services and workforce development.

Another education development that is expected to impact on health is the *Curriculum for excellence (11)*, a major review of the curriculum for ages 3–18. Health and well-being is one of the compulsory strands to be covered by all education practitioners, covering mental, emotional, social and physical well-being, health promoting schools, physical education, physical activity and sport, food and health, substance misuse and relationships, and sexual health and parenthood.

Two main areas of work have been taken forward by NHS Health Scotland. The first is the further development of “Walk the talk”, an initiative aimed at making primary care services more accessible to young people. This project has supported and compiled good practice, run a national conference, developed a web site and produced a DVD by young people on their views of services.

The second piece of work has been with children and young people who have been in the care of the state (looked after and accommodated children and young people) which has included research on the knowledge and understanding of improving health of different groups of staff and a comprehensive resource pack on health for staff in residential care settings.

The recommendations of the subgroup report and their implications for NHS Health Scotland were taken to the organization’s board in July and November 2007, and approval was given for expanding capacity to work on children and young people’s health.

A further work area is exploring the links between environment and health. Through its work to develop a strategic framework for environment and health, Scotland is taking steps to look in new ways at the relationship between environment and health and use the product of this analysis to better inform policy. The contribution this will make to securing a physical environment which is safe, hazard free and genuinely promoting of health and well-being is intended to be of benefit to all age groups, but the focus for a three-year initial prototype phase of the work will be the health of children from preconception to eight years, seeking to better understand and address the environmental determinants of four key health outcomes in this age group:

- asthma
- unintentional injury
- mental health and well-being
- obesity.

The work has strong links to *Children’s Environment and Health Action Plan for Europe (16)*.

Next steps and key challenges of the national implementation process

The next steps in the national implementation process relate to actions across a range of different policies. The challenge is to ensure that the key areas identified move forward in harmony and that coordination and support for implementation and review are in place. While there is a great willingness to move forward, the need to take time to involve practitioners to ensure policy is feasible and locally effective and to put in place a proactive and comprehensive implementation strategy was emphasized in discussion.

Participants expressed the view that much remains to be done, particularly with regard to inequalities, parenting, mental well-being and workforce development.

Planned future actions, expected outcomes and international support needed

Specific recommendations from the subgroup and broader child and adolescent health issues are being taken forward in Scotland through a wide range of policies involving the health and education sectors.

WHO has been asked to present the Scottish case study in the context of broader European work on child and adolescent health strategies to CYPHSG and others to inform further development.

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Analysis of interviews and roundtable discussions

Political commitment

Political commitment was seen as strong. Participants in the interviews and roundtables were unanimous that in general, the policy direction was extremely favourable to the health of children and young people. It was noted, however, that major changes in government, particularly the concordat between central and local government, were still to be tested. Implementation of policy, evidence of demonstrable action and beneficial effect and commitment to follow policy through are crucial.

The major changes brought in by the concordat on national outcomes were supported by participants, as they have increased the emphasis on joint working and created a focus on outcomes rather than activity. The outcomes have received support, as have the range of indicators provided, as they enable some local flexibility. In general, it was felt that it is too early to see if these major changes will be effective.

A key limiting factor is seen as the difficulty in developing new services, or redesigning old ones, without specific transition funding. In the past, this has come from central government, but with the concordat such “ring-fencing” (or protecting) of funds no longer happens. Mechanisms and funding to support implementation were not seen as being clear or “tried and tested”, and this has implications for achieving the partnerships, shared agendas and budgets across sectors to achieve the overarching aims.

The leading role of key individuals was noted, in particular the current Chief Medical Officer in Scotland whose most recent report focused on child health and who made a major contribution to the development of the Ministerial Task Force on Inequalities in Health and the resulting report *Equally well* (13). The importance of the very early years is seen as crucial within this work. Interviewees saw this level of commitment as important in supporting future work.

The guiding principles

Youth participation

Good examples of young people's participation were cited, including:

- Young Scot, a national organization which receives sponsorship from NHS Health Scotland and the Scottish Government, has developed mechanisms for consultation and involvement (such as web based consultation) which are well regarded and frequently used by young people;
- the Scottish Youth Parliament, a nationally representative body with a health committee who are routinely involved in consultations;
- Dialogue Youth, a local authority-based system set up to improve dialogue with young people in Scotland;
- a joint project between the Children and Young People's Commissioner and NHS Education for Scotland which has set up a Young People's Health Advisory Group that has been used in developing guidance in areas such as adolescent care;
- pre-existing groups of young people who took part in an early-stage conference related to the European Strategy; and
- young people have been involved in developing the *Getting it right for every child* strategy (3) and the planning for two new children's hospitals (due to open in 2013).

It was noted that there is no youth participation in CYPHSG, and young people's lack of involvement in the development and dissemination of research should be addressed.

Participation of civil society

The view was that the national strategy on patient and public involvement has had an effect, and that public participation has now become a routine element of services. This is usually at the consultation stage, although the churches were actively involved in development of the sexual health strategy.

Public involvement in health services should be subject to ongoing review and good practice on working with children and young people should be embedded in approaches to encouraging civil participation, it was felt.

Life-course approach

There is not a well-articulated or comprehensive life-course approach evident within Scotland. There is a focus on many life stages, but this has not developed as part of a planned life-course approach; rather, it has emerged in responses to particular health issues, with the age or life stage of affected individuals being considered secondary.

Scotland has long-standing maternal and infant health policy which is subject to periodic review. The need to ensure that services reach young mothers and mothers in deprived areas, for instance, is currently being looked at, as is the need to address high levels of smoking in pregnancy and low rates of breastfeeding. The lack of emphasis on policy on fathers, however, was noted by interviewees. The policy lead on parenting lies within the education sector, but the need for a strategic focus on parenting and health was identified, particularly in relation to achieving consensus around parenting programmes used by health professionals.

Strong views were expressed on the need to focus on the very early years (children who are under two years). Interviewees were worried that with education being designated as the lead sector for children, the importance of the very early years for health in the short and long term may not receive the emphasis it should. One interviewee defined the importance of these early stages of life as being “mission critical”. Collaboration between the education and health sectors was seen as being active once the initial direction has been set, rather than the sectors getting together to develop joint policy. This could be compounded by the different ways in which the sectors operate, with the education sector using systems of inspection, and the health sector adopting evidence-based standards and audits. Interviewees noted that the health sector had a responsibility to demonstrate the strength of the evidence to influence strategy, policy and investment in the earliest stages of life.

A gap area for health services was also seen for the 5–12 age group. The development of health promoting schools was valued and the health and well-being strand of *Curriculum for excellence (11)* was considered important. Long-term care of children with complex health needs, particularly as they reach adolescence, was of much concern to health care practitioners from all professions. The needs of adolescents within specialist care and primary care are currently being addressed through, for example, the age-appropriate care section of the *National delivery plan for children and young people’s specialist services in Scotland: draft for consultation (6)*, but there was a recognition that much of the work focusing on young people has had a rather negative preoccupation with lifestyle.

It was noted that it is important to focus on transitions within a life-course approach, particularly the existing service gap between school and adult life. In general, a longer-term approach to planning and coordination across the lifespan could be valuable.

Equity

Issues related to inequities were of major concern, with socioeconomic deprivation identified as the greatest challenge. The scale of deprivation in some areas of the country is such that it was perceived as almost creating a social underclass in which disadvantage is entrenched. Specific groups were highlighted as vulnerable: young parents, and children in families affected by domestic abuse and substance misuse. The report on children and young people cared for by the state, *Looked after children and young people. We can and must do better (14)*, is addressing the needs of children in the care of local authorities and broader inequalities in health will be addressed by *Equally well (13)*.

Gender

Gender issues were raised with respect to girls’ and young women’s lifestyles, where it was noted that there are many aspects (smoking, alcohol, mental well-being, impact of early puberty, increase in referrals to children’s panels) where they fare much worse than boys.

Intersectoral action

The general view was that there was good multiagency involvement in strategic work, particularly at local level through CHPs. The new collaboration between the Scottish Government and local authorities in the early years framework (15) is seen as changing ways of collaboration at national level.

It is clear that the voluntary sector is actively involved, but representatives from the voluntary sector indicated that their contributions were being spread across many committees and groups with no overall coordination. This was characterized by one participant as the voluntary sector “being at all the right tables, but with no single, overall table”.

Links between research and policy were discussed, with the suggestion that academic researchers could do more to disseminate their findings to policy-makers.

Improving health systems

Coordination

It was felt that CYPHSG was the nearest thing Scotland had to a national strategy group, but interviewees noted that its role was advisory. It was seen as developing proposals around key areas rather than acting as a group with an overarching responsibility for strategy. It was noted that general practitioners (GPs) are not represented on the group, yet consultation with very young children and their families forms a major proportion of the workload in general practice.

The interviews indicated a key strength in that all the relevant agencies and people were involved in developing policy. Interviewees expressed concern at the lack of an articulated prioritization process for policy and the range of drivers that impact on health policy in Scotland. Some described the situation as “maintaining the status quo until something happens”, such as a health incident or media coverage of a health issue. In this sense, policy can be reactive rather than proactive. This suggests a need to establish a formal system of coordination and review. Despite this, recent major developments include healthy weight interventions for children, the appointment of a national maternal and infant nutrition co-ordinator and inspection for child protection services.

Although the subgroup work noted the policies on violence and injuries, the view was taken that given the rates of injury and violence related to injury in Scotland, there would be benefit in a comprehensive strategy on this issue.

Stewardship

A number of systems are in place to manage and review the quality and standards of health care in Scotland. Ultimately, the NHS in Scotland is accountable to the government minister and the parliament. All health board member appointments are subject to ministerial approval, and each area health board has local authority representation. Additionally, each CHP within health board areas has a local board in partnership with the local authority and patient representatives. All boards have committees for clinical governance and systems of quality assurance and audit.

At national level, NHS Quality Improvement Scotland (QIS) has a leadership role. Specifically, QIS sets national standards for a range of services, such as for screening services, provides guidelines in areas like oral health in children), carries out health technology assessments and develops best practice statements. It also oversees a national process of peer and lay review against standards. Independent audit is carried out by Audit Scotland, and national targets for performance management are set by the Scottish Government.

The national systems of inspection of education and care are separate, but also impact on the health and well-being of children.

Financing

Strong financial support has been given to the review of specialist services for children and the development of new children's hospitals, and is being attached to some of the HEAT targets that relate to child health. In contrast, however, some national health policies, such as the strategy for child and adolescent mental health, do not have funding attached.

Generally, it was felt that children's services lacked power in relation to competing for funding with adult services. It was noted that the main recipients of funding tend to be services associated with national targets, such as those which have an impact on reducing waiting times, rather than child health.

Health services

The key strength is that health services are free to children and young people (up to the age of 16, or 18 if in full-time education; full-time students over 18 years are entitled to reduced fees where fees exist, such as for dental treatment). It was noted, however, that uptake of services by vulnerable groups is poor, and that young people generally do not access services.

Participants were able to identify gaps in health services. It was felt that although the quality of services on the whole was good, provision of services varies across the country, often reflecting geographical constraints and specific cross-boundary issues between health board areas. In general, it was the most vulnerable populations who were losing out, with a major service gap being identified in child and adolescent mental health services.

All interviewees commented on the key strengths of the workforce, with particular acknowledgement of: the commitment of staff; the establishment of the Royal College of Paediatrics and Child Health; the creation of consultant-level posts in midwifery and the allied health professions; and the growth in posts that are jointly funded by health and local government. A number of current workforce issues were, however, raised as being critical for child health, including:

- the review of nursing in the community in Scotland (17), through which pilot sites are testing the amalgamation of existing nursing roles; the process was seen as threatening to the current role of health visitors in working with families with young children;
- proposals for changes in school nursing and the development of a school health resource; and
- changes in general practice which mean that fewer GPs will have experience in paediatrics.

These workforce changes are being accompanied by changes in practice, such as child health surveillance programme alterations following the Hall 4 guidance (9). Anecdotal evidence indicates that families assessed under this system that had been identified at an early stage as not needing additional support were being referred for therapy at a later stage.

The importance of the wider early years focus is expected to be developed by the early years framework (15).

Managed clinical networks (MCNs) which draw together clinicians working in different areas who have the same remit have been established in recent years. MCNs may be locally for common health issues, but are set up on a regional or national basis for specialties such as paediatric cardiac surgery, renal surgery and cleft lip. The configuration of these has formed part

of the *National delivery plan for children and young people's specialist services in Scotland: draft for consultation (6)*. Care pathways across services and individual care plans have been developed alongside this approach.

Information systems

A clear distinction was made between national and individual data systems. National data systems were seen as a key strength. Basic demographic information is held by the Office of the Registrar General for Scotland, which retains records of all births, deaths and marriages and holds the decennial census information. The main source of routine health information is the NHS Information Services Division (ISD) and much of the information profiled in the information tool is collected by ISD. Although there were some concerns about how well some of the databases were completed locally, they were seen as providing consistent and comprehensive information over time.

Most ISD information can be disaggregated by age and sex, and most data include the patient's postcode, which allows calculation of deprivation status based on the immediate locality. This can be used instead of an individual's socioeconomic status. Systems include immunization and screening databases and pregnancy, maternal and child health information. Further information is available through regular surveys such as the Scottish Health Survey. Information on educational attainment is collected by individual local authorities and submitted to government.

The aim in *Getting it right for every child (3)* of creating a single shared assessment was viewed as critical. There is a framework for integrated assessment, but as yet recording systems do not support it. The problems of sharing data remain despite national initiatives.

Declarations and conventions

The MDGs were not recognized by interviewees and are not generally referenced in Scottish policy for children.

The Office of the Children and Young People's Commissioner was set up in 2004 with a key remit to take an overview of children's rights in Scotland. It has reviewed the implementation of the CRC and has a major role in researching and reporting on specific issues. The Commissioner's reports are well regarded, well publicized and influential. Most policy for children and young people refers explicitly to the CRC.

Summary of the United Kingdom (Scotland) case study

An overall picture has emerged of overlapping areas of development with common stakeholders accessing the same reports and research, one of these being the European Strategy. Influences from this work are not always articulated but can be identified as influencing the ongoing work plan of CYPHSG and others. Current work clearly supports the European Strategy key objectives

In terms of implementation of a child and adolescent health strategy, the picture is mixed. There are many strong areas, a highly committed workforce and a collection of major policy and legislative initiatives, some of which are long standing and well implemented, and some of which have yet to be implemented. There are systems of data collection, performance management and standard setting in place which should enable impact of policy to be measured and reviewed. The use of the tools and the case study, however, indicated gap areas and concerns.

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Case study – Uzbekistan

Background information on Uzbekistan

Uzbekistan is located in central Asia. Recent estimates suggest the total population is 27 million, which represents growth of more than double since the 1970s. High population growth rates have gradually decreased, with population growth in 2005 being 1.5%. This slowdown can be primarily attributed to decreasing birth and fertility rates, as death rates have slightly declined (1).

Declining population growth is reflected in a changing demographic structure and age-dependency ratio. The share of the population aged 0–14 decreased from 45% in 1970 to 33.2% in 2005, while the age-dependency ratio declined by 40% over the same period. The population over 65 years of age has also decreased, although the overall demographic trends imply an ageing of Uzbekistan's population in the long term (1).

Poverty in children is very high in Uzbekistan, with an estimated 50% of the child population experiencing poverty in 2002/2003. The under-five mortality rate has slowly decreased from 1990, although it is still very high (as is the case in other countries in central Asia). It decreased from 79 deaths per 1000 births in 1990 to 69 per 1000 in 2003.

The nutritional status of children is also a worrying issue, particularly in rural areas, where an estimated 37% of the population lives. There is a strong interaction in rural areas between food availability, nutritional practices and knowledge and poor sanitation. As UNICEF has reported (2), concentrations of micronutrient deficiencies are particularly high in certain areas, such as the Aral Sea in Uzbekistan and Kazakhstan, where they are linked to lack of safe water and poor sanitation. UNICEF also states that the health examination survey carried out in 2002 in Uzbekistan found that over half of the children aged less than three years were anaemic, but that this applied to only 20% of those in the capital city, Tashkent. The survey also indicated that 53% of children aged 6–59 months suffered from vitamin A deficiency, while earlier studies carried out in a district next to the Aral Sea had shown a level of about 40%. The UNICEF report goes on to state that between one third and one half of young children in Azerbaijan, Georgia, Kazakhstan, Tajikistan and Uzbekistan suffer from iron-deficiency anaemia.

This is an issue of particular concern and has been included in the BCA between the Ministry of Health of Uzbekistan and the Regional Office for 2008/2009. The BCA established specific objectives relevant to child and adolescent health, namely “stewardship function strengthened for improving access, quality and use of maternal, newborn, child and adolescent health care services” and “strengthened services for effective maternal, perinatal, newborn, child and adolescent care through continuum of care and primary health care approach”.

Case study narrative

Overview

Initiation of the national implementation process

Health and education of children and young people have been priority areas for the Government of Uzbekistan since independence was achieved in 1991. Uzbekistan has committed to achieving the MDGs, of which several are directly or indirectly concerned with child and adolescent health and development.

After the adoption of the European Strategy by WHO in September 2005, the Ministry of Health initiated a process of national child and adolescent health and development strategy development. Developing the strategy is seen as an important activity in guiding and supporting work in Uzbekistan aimed at achieving the MDGs.

There was no comprehensive child and adolescent health and development strategy in Uzbekistan until 2007, but policies on maternal and newborn care had been developed, including “Making pregnancy safer” and “Integrated management of childhood illness and breastfeeding”. The Regional Office and the WHO Country Office have provided support and technical assistance to the Uzbek Ministry of Health throughout the process of developing and implementing these policies over the past two decades. WHO has supported Ministry of Health and Government representatives to attend focal point meetings in Cyprus (2005), Turkey (2006), Spain (2007) and Italy (2007). WHO also facilitated the workshop on the development of a national child and adolescent health and development strategy and action plan held in March 2007 in Tashkent.

An intersectoral working group was created under WHO Country Office facilitation. Several meetings have been held and contact people from different sectors have been identified. The Ministry of Health, as the lead sector, has drafted the strategy document with contributions from other sectors. The National Professional Officer for Family and Community Health at the WHO Country Office in Tashkent facilitated the process.

Funding and resource mobilization mechanisms

Uzbekistan currently receives substantial funding for health system development and health programmes. The Government, working with WHO, plans to set up a database for main donors and projects. Coordination of donor activities is the responsibility of the Government Department on Foreign Investments. The United Nations country team, through the common country assessment (CCA) and United Nations Development Assistance Framework (UNDAF) processes, has outlined priorities for collaboration for the period from 2005 to 2009. The World Bank leads work on health system reform, while the Asian Development Bank (ADB) and UNICEF focus on health programmes for mothers and children. The World Bank provided a loan of US\$ 80 million for the “Health I and II” projects, which were aimed at: strengthening the primary health care system; providing education for health staff; supplies of technical equipment, medicines etc.; and improving financial management. ADB provided a loan of US\$ 40 million to improve maternal and child health. Finally, WHO is expected to play an important role in reforms through the BCA.

Main actors in the development of the national strategy

After the national strategy development workshop on child and adolescent health and development, which was held in Tashkent on 27–28 March 2007, an intersectoral working group was established, supported by the Cabinet of Ministers. The intersectoral group consists of representatives of nine main stakeholders including nongovernmental and youth organizations. It includes: the Ministry of Health; Ministry of Public Education; Ministry of Labour and Social Protection; Ministry of Finance; Women’s Committee; Centre of Social Adaptation of Children; the youth organization “Kamolot”; the Children’s Parliament “Learning for life” project; and the National Paediatric Institute.

The WHO Country Office facilitated several meetings with the working group. The role and contribution of each actor was identified, based on the European Strategy information, assessment and action tools. The lead sector and partners were identified for each priority area to ensure their input to the strategy document. Respective contributions were based on the assessment of the existing situation, needs and priorities. Project HOPE/USAID will provide support in developing the strategy document.

Background and national context

Introduction of the European Strategy

The Mother and Child Health Department of the Ministry of Health is in charge of the introduction and dissemination of the European Strategy, and the Deputy Minister is the focal point. The national process was initiated through the national workshop. The Regional Office and WHO Country Office provided support through participating in the workshop, providing technical expertise and closely collaborating with all involved institutions. Assessment of current policies and programmes was carried out by the Ministry of Health, with WHO support.

A team from the Regional Office facilitated the national workshop in March 2007, and a team from WHO headquarters and the Regional Office then visited Uzbekistan in September 2007 to provide technical support for strategy development. They met with a representative of the Cabinet of Ministers, the Deputy Minister of Health, child and adolescent health and development strategy focal point and task force team. Officers from the Regional Office visited Uzbekistan in November 2007 to follow up the strategy development process and conduct case study roundtable discussions and interviews, and the National Professional Officer of Family and Community Health at the WHO Country Office facilitated regular meetings of the task force intersectoral working group.

Main outcomes of the national workshop

The main outcomes of the workshop were:

- development of a framework for evidence-based review and improvement of national policies and programmes for child and adolescent health and development, based on the life-course approach;
- identification of multisectoral action to address the main issues in child and adolescent health; and
- definition of the role of health and other sectors in developing and coordinating policies and service delivery to meet the identified needs of children and adolescents.

Dissemination of the European Strategy and related tools

More than 100 copies of the European Strategy and the information, assessment, action and gender tools were distributed in the country through the national workshop, task force meetings, country visits and other activities.

Existing national strategy before September 2005

There was no national strategy on child and adolescent health and development before September 2005, but there were national policies on maternal and child health, including “Making pregnancy safer”, “Integrated management of childhood illness and breastfeeding” and others which complemented the national programme on improvement of mother and child health and the Cabinet of Ministers Decree 242, 2002: “Increasing health knowledge of the population through health education”. The national programme integrated different sectors’ major goals, policies and actions in relation to improving maternal and child health. It also provided the long-term action plan (2002–2007) and financial resources to achieve defined goals.

National experiences of the development process

National development process up to October 2007: main actions, outcomes and international support

The European Strategy was introduced in Uzbekistan in September 2005. Ministry of Health and Women’s Committee representatives attended Regional Office meetings between 2005 and 2007. Assessment of existing policies and the current situation was carried out in 2006 by the Ministry of Health, with the assessment report being presented at the national workshop in March 2007.

The first draft of the strategy was developed by the Ministry of Health through the Paediatric Institute in September 2007. No contributions were provided from other sectors in this first draft, so it became a very health-oriented document. WHO initiated several missions and meetings between September 2007 and January 2008 which aimed to improve involvement of relevant sectors and youth organizations and to promote the work of the intersectoral group. The roles and contributions of the main sectors and partners were defined and the timetable agreed during the meetings.

According to a representative of the Cabinet of Ministers, the revised child and adolescent health and development strategy will be used as a basis for the next national programme on maternal and child health (2008–2012).

Use and applicability of the European Strategy tools

The European Strategy tools were widely distributed and are now being utilized by working group members to finalize the strategy document. They proved to be very useful in the strategy development process, as they provide guidance to members of the working group.

Use of experiences from other countries

Experiences from other countries were not used, but the Uzbek experience of the development of the reproductive health strategy was very useful, especially in relation to experience of multisectoral work.

Main lessons learnt from the national implementation process up to October 2007

The main lesson learnt from the national implementation process is the importance of involving the representatives of other sectors, which contributed to strengthening the strategy.

Future actions

Next steps and key challenges of the national implementation process

The main priority areas of child and adolescent health and development are already being implemented in Uzbekistan as part of Government and Presidential Decrees on maternal and child health care.

Planned future actions, expected outcomes and international support needed

The following actions have been identified:

- intersectoral working group discussion of the draft child and adolescent health and development strategy and plan of action (February and March 2008);
- workshop for stakeholders with participation of Regional Office representatives to review the draft of the child and adolescent health and development strategy and plan of action (April 2008);
- preparation of the child and adolescent health and development strategy and plan of action and submission to the Council of Ministers for approval (May 2008); and
- implementation of the plan of action of the child and adolescent health and development strategy.

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Analysis of interviews and roundtable discussions

Political commitment

The Ministry of Health was clearly defined as the leading stakeholder in the development of the strategy. The overall commitment from the government towards the health and development of children and adolescents was regarded as strong and long term, which is reflected in governmental programmes. The strategy and implementation plans were characterized as being in line with political priorities and health sector decrees. The fact that the priorities are streamlined with the MDGs underlines a strong political commitment towards children and adolescents:

Uzbekistan has adopted the MDGs and we know that therefore mother and child health is a priority. There was a Presidential Decree in September about further strengthening maternal and child health. So we think that this is proof of their commitment (roundtable 2).

While stakeholders characterized health sector commitment as being high, other sectors' commitment was regarded as being more uncertain. Collaboration with the financial and social sectors is limited in the present strategy development process:

The Ministry of Health has the main role in developing and gathering all the different parts and inviting different stakeholders to be involved in the development process. The Ministry of Education is included a bit. But in my opinion, they cannot promote different issues like social or labour issues for youth (representative, WHO Country Office).

Actors agreed that information about, and agreements on, different sectors' financial, human and political resources for strategy development and implementation are urgently needed.

Distribution of work tasks

There was lack of clarity for most stakeholders on the distribution of work tasks and responsibilities. Several interviewees representing international agencies claimed that it was more-or-less clear in which area they needed to focus, but there was no obvious division of responsibilities:

Concerning UNFPA, we have an idea where we are going to work, but we do not have a clear division of responsibilities, so I think that the Government should take the leading role in this. We in the national organization have a broad sphere of activities, so we can work in different activities and support Government initiatives. But so far, we do not have a clear-cut division of responsibilities (roundtable 2).

The Government was identified as the leading actor regarding identification and distribution of tasks and responsibilities. Among other things, this was identified as being helpful in avoiding the usual overlap between the activities of different stakeholders.

It was suggested that one focal point should be selected as a representative for each organization or institution to ensure transparency and information-sharing among stakeholders during strategy development. The same person would consequently be involved in the process consistently, instead of someone new being sent to each meeting.

Several actors raised doubts about commitment to implementing the strategy:

I think that technical support is needed in respect of implementation of the European Strategy. Like the addition of information, materials and experiences from other countries, and maybe we need

some training in this respect, because of course we have human resources that are specialized and skilled in these methodologies. But we would need training to implement (roundtable 1).

There seemed to be a great need for technical support with regard to further implementation of the strategy, the supply of which would increase the commitment to action.

Accessibility to, and integration of, different types of information need to be improved. This would strengthen the credibility of the strategy document and action plan and enable their implementation. Strengthening collaboration among stakeholders would help in clarifying the distribution of work tasks and responsibilities and would reinforce the integrated approach of the strategy:

There is a lack of coordination between the different programmes. Projects are not very sustainable; they may finish and the next project is not logically succeeding or following the previous one. And especially in regard to motherhood and child care projects, if someone can coordinate all the projects and if there is some matrix of outcomes, results and successes of the projects and programmes, it would be very good (roundtable 2).

Several stakeholders suggested holding regular meetings and roundtable discussions, some advocating that they be held quarterly, with the aim of improving cooperation among stakeholders.

The guiding principles

Youth participation

Generally, interviewees felt that young people should be involved in the development of a national strategy for child and adolescent health and development, but it was recognized that youth participation currently is inadequate:

Involvement of the young is not sufficient. They are involved to a certain extent, mostly in activities, but not at the political level. When it comes to monitoring and decision-making, we just inform them and then involve them in our activities. The development of any strategy should be based on the needs of the users, and in our case it is children and adolescents, who from the very beginning have real needs that should be considered (roundtable 1).

Meetings in which young people can share ideas have been held in Uzbekistan. Many stakeholders stated, however, that although young people are involved, they do not directly participate in strategy development at the same level as other stakeholders.

Youth participation takes place mainly through the youth organization “Kamolot”, which was regarded as an important resource for strategy development and implementation. The organization’s presence throughout the country made it an appropriate entry point for young people’s participation, stakeholders felt. “Kamolot” has experience in involving young people primarily through the peer-to-peer education approach, in which young people’s needs and new approaches to advocacy of healthy lifestyles have been identified.

Participation of civil society

Two important civil society actors were identified through the interviews: the community councils “Mahallahs”, and the Women’s Council. Both groups are participating significantly to the development of the strategy. They work at community level and represent parts of the population living in both central and remote areas of the country.

Life-course approach

The life-course approach was generally regarded as a useful framework for the strategy as it ensures the systematic inclusion of all relevant age groups:

I think that this life-course approach also will help us to distribute human and financial resources accordingly. For example, you see that there is a gap and that we have lack of resources somewhere or even a lack of attention from the Government. So we can see how it will affect other places where we need improvement. For example, we can see that there are good efforts which were put into newborn care, but we lost something during antenatal care (representative, WHO Country Office).

On the one hand, stakeholders recognized that extensive attention has been directed towards mothers and children through interventions on reproductive health and integrated management of childhood illness, among other measures. On the other, it was also evident that adolescents, especially the 15–18 years group, had not received sufficient attention, despite the fact that this age period is critical with regard to the development of risk behaviours and healthy lifestyles. Consequently, there was comprehensive agreement on the need for strong interventions focusing specifically on adolescents' health and well-being.

Equity

Different opinions were expressed regarding inequities between different population groups in Uzbekistan. It was emphasized that the Uzbek Government is very attentive to at-risk groups in the population, with equal access to health care and free contraception being examples of action to reduce inequities.

There nevertheless seemed to be extensive differences in the health status of different population groups, such as between urban and rural populations and between men and women, and also in the health status of at-risk families such as low-income families and families with an HIV/AIDS positive person or a disabled member:

I agree that we do not have problems at national or political level. We do not have such groups. But if we speak about socially vulnerable groups, we are aware of the fact that we have this type of problem at regional level or at community level, we have the groups of the population who have problems accessing services (roundtable 1).

According to various stakeholders, more information is needed on how to address such inequity issues. More specifically, actors requested information on how to reflect the need for social and psychological support of families in the national strategy:

We have already included vulnerable children in the strategy. But we also need to work with the parents of these children. We need to work more on this issue at regional level to raise people's awareness of the need to include this in the strategy (roundtable 1).

Several activities are already ongoing in relation to at-risk families. There is a special committee in which all ministries, agencies and several specialists are represented. This group evaluates interventions and the legislation that is designed to support vulnerable families. It was suggested that this work should be reflected in the strategy to further strengthen the effort to support vulnerable families.

Gender

Stakeholders commented that there is a reluctance in Uzbekistan to separate programmes for boys and girls in the belief that interventions that consider the genders equally ensure equality of treatment. Actors seemed to agree that there is no gender discrimination in legislation and public regulations. Several stakeholders nevertheless emphasized that girls in some families are primarily considered as potential brides. This sometimes results in families trying to conceal health problems girls may have in order to enhance their chances of making a good marriage. Consequently, the imbalance in health services provided for boys and girls arises as a result of cultural and social attitudes rather than because of the nature of the health system. All stakeholders agreed that this issue needs to be studied more thoroughly to inform responses to the problem:

We have to take the national mentality into consideration. We cannot always trust the statistics we have. I work as an endocrinologist. Sometimes only boys with diabetes are brought to see us, and we are told that girls are not being registered. When I asked why this is so, families say: ‘She has to marry, and we don’t want people to know that she has diabetes’. And due to this, girls sometimes don’t get help, which has an impact on their health (roundtable 2).

A gender analysis has recently been carried out in Uzbekistan, but the analysis was restricted to specific health issues which turned out to be too limited to allow a proper study of the broader circumstances of gender-related inequalities:

Yes, we did carry out the gender analysis. But I think that in doing the assessment, the gender situation, the gender review, the gender analysis, the only focus was on health. And I know we have a lot of information in the country on gender from different programmes, so I was able to find a lot of sources. Maybe we should do a bigger analysis than we did, before the workshop ... where we focus on health (representative, WHO Country Office).

There was a broad understanding that the gender issue is crosscutting and should therefore be included as a “horizontal” component in strategy development. Stakeholders agreed that the Ministry of Health only has part of the mandate when incorporating gender into the strategy; the gender analysis carried out recently should be extended to areas other than health, since the problems seem to stem from social, cultural and economic issues.

Intersectoral action

Stakeholders reported that good intersectoral relationships have been established at ministerial level during the last five years. A committee has been created with the mandate of coordinating all interrelated ministry programmes. In general, collaboration between ministries was regarded as positive, creating a common understanding and an encouraging attitude towards the work of others. There is already much experience in multisectoral collaboration in Uzbekistan and several programmes based on collaboration among sectors have been developed and implemented. The approach was believed to encourage greater responsibility among different sectors and to create comprehensive programmes.

Some stakeholders provided examples of intersectoral action, such as the strategy on reproductive health. This has resulted in a comprehensive strategy based on consensus and through which the standpoints of different sectors are reflected; the strategy has, however, come to a standstill within the Cabinet of Ministers, from whom approval is necessary for implementation. It was emphasized in the roundtable discussions that it would be an achievement in itself to make people meet and discuss the topic of child and adolescent health and development.

Collaboration on the strategy on child and adolescent health and development has not yet reached the level where people meet and agree on how to incorporate the different issues:

I think that the stakeholders share their opinions very openly. It is good cooperation. But the level of sitting together and putting the issue together is still weak. I hope that we will improve discussions and sit together to put a part of the strategy together or share questions and comments. It would improve our cooperation. But we are not at that level right now (representative, WHO Country Office).

Constantly changing group membership and limited information-sharing with other representatives of the ministry were highlighted as problems related to intersectoral action. Representatives at the meetings do often not have decision-making capacity within their ministry and rarely have enough time or opportunity to provide feedback to their superior. Valuable discussions are consequently lost. Follow up of multisectoral meetings also becomes uncertain.

Improving health systems

Stewardship

Stakeholders agreed that the priorities of the European Strategy are not new to the work being carried out in the country on child and adolescent health and development. Most of the priorities are already being manifested within programmes and projects that existed prior to the development of the national strategy. The maintenance of existing priorities at country level creates a clear feeling of continuity and means funding and functionality for each of the priorities are in place.

Although the representatives are planning to include all seven priorities of the European Strategy action tool into the national strategy, several stakeholders suggested that the priority of “accidents and violence” seems inappropriate in the Uzbek context, because violence is not an issue in society. Several suggestions for modification of the priority were made, with “accidents and trauma” receiving widespread support. Replacing “violence” with “neglect” was also proposed.

In relation to identifying priorities, representatives referred to the regular collection of statistical data and the situation analysis based on the assessment tool of the European Strategy which collected information from several international agencies within the country. Information from the situation analysis underlined the demographic justifications for prioritizing children and adolescents, since they constitute almost half of the Uzbek population. This is in itself a great motivation for many actors, but there seems to be a gap between the identification of priorities and actually addressing the priorities in the strategy:

Priorities were well identified. But addressing these priorities in a strategy is quite hard. The strategy is written by health people; that means the health part would be the best part of the strategy. If we could involve and include the different sectors more and more, it would mean we would receive more ideas for the strategy to address and be able to include all priorities (representative, WHO Country Office).

There is a link between intersectoral action and addressing the seven priorities within the national strategy. Expertise is required from other sectors to address certain priorities comprehensively, and priorities within one strategy need to be coordinated with those in other

sectors. Stakeholders stated that the biggest problem in setting priorities is the fact that priorities change over time and between different ministries and organizations.

Financing

Financial resources for the development and implementation of the strategy were generally regarded as being in place and being assured in the short term. Financial allocations were closely related to the priorities defined in the strategy. It was felt that the strategy will help to ensure sustainable funding for child and adolescent health and development, but sustainability was questioned within a roundtable discussion:

There are no special financial allocations for children and women. Funds are allocated for the health sphere in general. Where the funds are allocated depends on the Ministry of Health and health departments in the regions and districts. That is why we cannot speak about sustainability of financing. We don't have the mechanisms for supervision and control and the prerequisites to say that allocations are needed for certain spheres (roundtable 2).

It was claimed that funding was nonspecific, and this was regarded as problematic when no assessment mechanisms were in place to guide where to disburse appropriate financial allocations. Several stakeholders requested assistance on financial decision-making, specifically in relation to cost-efficient allocation of resources.

Health services

Unequal distribution of medical equipment and human resources within the health care system was considered a general problem that creates inequity between rural and urban populations. Another important factor reported in relation to quality of health care was the prescription of drugs for children and adolescents. There is a perception that there is a tendency towards unnecessary prescription of drugs.

The quality of health services in Uzbekistan should be ensured through international standards, clinically developed guidelines and evidence-based medicine, according to most stakeholders. Refresher courses for doctors are held frequently in Tashkent, but some doctors are not able to participate due to travel distances and limited time. Some guidelines for doctors are not considered user-friendly. This means that an average doctor is not able to understand some of the clinical protocols. Several actors therefore recommended thorough monitoring and supervision of the use of protocols within the health care system:

There should be clear protocols, guidelines, supervision and monitoring of how well these protocols are observed. I think that this would ensure a certain amount of quality (roundtable 2).

The protocols should also be altered to enable all medical staff to understand them and act accordingly.

Information systems

The current quality of statistical data on child and adolescent health and development was questioned by most participants in the roundtable discussions. They stated that there are substantial deviations in statistics from the State Department compared to those collected by other agencies. The data are not sufficiently reliable and trustworthy to inform activity planning:

In Uzbekistan, there is no problem to collect the information, but the only thing is that we need to work on the reliability of the data. Especially at the level of regions and districts, where they make mistakes and errors that impact on the statistics (roundtable 2).

The collection of relevant data is going on, but the quality of the data at district and regional levels needs to be improved. Stakeholders agreed that there is a need for a common software system for databases, which could encourage a joined-up approach to the collection and use of data.

Interviewees provided contradictory information on the disaggregation of data by sex and age. Some actors stated that all data are disaggregated by both sex and age, while others claimed that data on child and adolescent health are never disaggregated. All stakeholders agreed on the fact that disaggregated data are needed to act on different circumstances and critical periods that characterize various groups of children and adolescents.

Data use and data quality were considered separately by stakeholders. It was emphasized that existing data are rarely used in decision-making in relation to, for example, prioritization of and improvement in interventions:

We have the statistical data, but whether they are used and at what level ... I think we need to carry out advocacy activities. We need to use objective statistics and criteria (roundtable 2).

One of the main problems reported was that much of the information is not being stored electronically. This means that very few centres use computers for monitoring activities; most still write reports longhand. Even when centres have computers available, their information systems and databases are rarely integrated with governmental information systems. This results in difficulty in harmonizing the indicators of each system.

The bigger health centres did not seem to have difficulty in requesting and attaining data from the Institute of Health, but a representative from a paediatric hospital suggested that data should be even more accessible by making the information public.

Declarations and conventions

The MDGs and CRC have been integrated into the national strategy. Most stakeholders claimed that the integration has been easy in the sense that the strategy took children's rights into account and is designed to contribute to the achievement of the MDGs.

Other contributions

The European Strategy was described as a common reference that will guide development of the national strategy. Stakeholders focused on the fact that the European Strategy helps to ensure that nothing important is left out of a national approach. All actors agreed that the national strategy should be broad and should reach beyond health care for children and adolescents. Making the national strategy broad will also assist its practical applicability, as all stakeholders will be able to find their specific “niche”.

Interviewees revealed that people perceive their work with the strategy as a process in which common goals are created, stakeholders’ views are broadened and mindsets are changed.

There is optimism about future implementation of the strategy, but it was emphasized that a unified approach adapted to the national context needs to be in place to implement the strategy successfully:

In piloting the strategy, we should take into account national specifics, conditions and culture. We cannot just implement things that have been successfully implemented in the rest of Europe and expect to get positive results here in Uzbekistan (roundtable 2).

Several stakeholders pointed out that the strategy should be analysed, evaluated and fine-tuned continuously. Regulatory documents should incorporate implementation of the strategy. It was also emphasized that priorities will change as time goes by, but that the main goals will stay the same. This enables the strategy to remain valid in the long term.

All stakeholders agreed that future involvement of the target groups is crucial:

One condition of success is: any development should be for people and implemented by people. We must involve people to the maximum degree. If we do not do that, we shall not have any sustainability (roundtable 2).

A unified approach will lead to a practical document that is easier to implement because it reflects common goals and is continuously fine-tuned to meet the needs of the population.

Summary of the Uzbek case study

The Uzbek Ministry of Health initiated the national strategy development process following the adoption of the European Strategy in September 2005, supported by the Regional Office and the WHO Country Office. Uzbekistan is in the final stage of preparing the national strategy document and action plan and is approaching the implementation phase. The main expected future actions are the formal approval of the strategy by the Council of Ministers and the consequent implementation of the strategy. The final child and adolescent health and development strategy will be used as the basis for the next national programme for maternal and child health (2008–2012).

The country has received support from WHO over the past two decades and from other international organizations, such as the World Bank, the Asian Development Bank and UNICEF, through different assistance programmes that have supported national reforms. The Regional Office financed the national workshop on child and adolescent health and development held in March 2007 and supported the participation of country representatives in relevant meetings throughout the WHO European Region. The Regional Office and the WHO Country Office also

provided continuous technical support to the national process, with the WHO Country Office facilitating the creation of the intersectoral working group, organizing meetings and identifying resource people from different sectors. The Regional Office is expected to play a larger role in national health system reform through the BCA.

The European Strategy was introduced by the Mother and Child Health Department of the Ministry of Health. The document and its tools were distributed through the national workshop, task force meetings and Regional Office missions in Uzbekistan. The information, assessment and action tools provided general guidance in the preparation of the draft national strategy and were used to identify the leading sector partners and their contribution to each priority area.

Regional Office technical and financial support was identified positively as one of the influencing factors. Great emphasis was given to the contribution provided by international organizations; their strong presence in Uzbekistan may be one of the main enabling factors in future strategy implementation by providing expertise in different programme areas and a predictable flow of financial resources. The constant presence of the main international donors in the country can also contribute to ensuring necessary continuity in strategy implementation activities.

The Ministry of Health was clearly identified as the leading stakeholder in the development of the strategy. The overall commitment from the Government towards the health and development of children and adolescents is regarded as strong and long term, which is reflected in governmental programmes. Commitment from other sectors, however, was regarded as uncertain.

In general, children and adolescents are considered important stakeholders in the process of strategy implementation, although their direct participation is mostly inadequate or insufficient. The most important contributor to youth participation seems to be the youth organization “Kamolot”, an important stakeholder that is present throughout the country. Two other civil society organizations were identified as contributing to representation of the population in central and remote areas of the country.

Country programmes in Uzbekistan have mostly focused on child and maternal health, but the life-course approach was generally regarded as a useful framework for the strategy. Doctors are now focusing more attention on the health needs of adolescents; indeed, comprehensive agreement has been reached that there is a need for interventions focusing specifically on adolescents’ health and well-being.

Different opinions were expressed about equity issues in Uzbekistan. Some at-risk groups were identified, such as those who live in rural areas, women, low-income families and families with a member who has HIV/AIDS or is disabled. Various stakeholders recognized the need to address these issues within the national strategy; they considered work already being done with at-risk families to be particularly important.

Gender was reported as being a challenging aspect of strategy implementation. Gender-related problems are socially and traditionally rooted, so the health service for boys and girls is a result of cultural and social trends rather than active discrimination against girls. It was agreed that gender must be a crosscutting issue that is included as a “horizontal” aspect of strategy development.

Good intersectoral relationships have been established at ministerial level during the last five years. In general, collaboration between ministries was regarded as positive, creating a comprehensive understanding and an encouraging attitude towards the work of others. Frequent change of personnel and the fact that representatives who do not have decision-making capacity are sent to intersectoral meetings rather than higher-ranking officials remain persistent challenges.

All stakeholders agreed that the priorities of the European Strategy are not new to ongoing work within the area of child and adolescent health and development. This means that most of the priorities are already included in programmes and projects that existed prior to the development of the national strategy. Maintenance of existing priorities at country level creates a clear feeling of continuity and confidence about the funding and functionality of each of these priorities.

Financial resources for the development and implementation of the strategy were generally regarded as being in place and being secure in the short term. Financial allocations are closely related to the priorities defined in the strategy. Consequently, funding would be certain if priorities are set according to the agendas of contributing partners and governmental stakeholders. Current challenges seem to be setting appropriate financial allocations and ensuring cost-efficient allocation of resources.

Different challenges exist in relation to health services in Uzbekistan, including: the unequal distribution of medical equipment and human resources within the health care system, which creates inequity between rural and urban populations and the perceived unnecessary prescription of drugs for children and adolescents. The quality of health services in Uzbekistan should, according to most stakeholders, be ensured through international standards, clinically developed guidelines and evidence-based medicine.

Health information in Uzbekistan was considered unreliable, particularly in relation to statistical information. Data are not stored electronically and are not used to inform interventions.

There is a strong commitment to, and integration of, the MDGs and CRC, but the significant problem of child labour has not been addressed due to its high political sensitivity.

Optimism exists regarding future implementation of the strategy, but it is emphasized that a unified approach adapted to the national context needs to be in place to ensure successful implementation. Implementation of the strategy should be continuously analysed, evaluated and adapted to meet new challenges and priorities.

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Feedback from the WHO workshop on “Implementing the WHO European strategy for child and adolescent health and development – lessons learnt”

The WHO workshop “Implementing the *WHO European strategy for child and adolescent health and development – lessons learnt*”, which took place in Florence, Italy in May 2008, provided detailed feedback on the country case study findings and from other countries using the European Strategy. Feedback was generally positive, with participants reflecting on the successes, barriers and challenges that characterized national processes.

Three areas received extra attention at the workshop: defining, integrating and evaluating national strategies. This section elaborates on workshop comments in relation to these three aspects. Its conclusions are based on country presentations on national processes, plenary discussions and group work on strategy development.

Defining the strategy

Most participants expressed a need for clear definitions of the role and expected outcomes of national strategies. One way to achieve this would be to develop a basic document stating clearly what the purpose of the strategy development and/or review was, what progress could be expected from the process and what professional and political contributions were needed in the initial phase. Suggestions regarding the placement of the strategy in relation to other strategies and national programmes would also be relevant. In other words, it would be helpful to state where the strategy on child and adolescent health and development fits into the current structure of national initiatives. This document would serve as an advocacy document that could help bring all relevant stakeholders on board at an early stage. It might also be of use in fundraising for activities related to national strategy implementation.

Integrating the strategy

Integrating the strategy at national level was seen as one of the main challenges in national processes. There seemed to be different perceptions of what it means to integrate the strategy at national level; all of these perceptions turned out to be relevant in relation to developing and/or implementing national strategies. Within the health sector, the strategy was regarded as a document that should be integrated with existing health strategies, especially those concerning child and adolescent health and development, reproductive health, gender and maternal health. It should be integrated into the health budget and health services in a comprehensive manner, so that the strategy can be turned into action.

Questions were raised about what was needed to implement the strategy. There seems to be a prevailing mindset among stakeholders that no strategy can be developed without financial resources having been allocated for the purpose. At the workshop, however, participants recognized that it might also work the other way around: no financial allocations for the national strategy may be made available without an existing strategy document. The question was therefore: *no money, no strategy*; or *no strategy, no money*?

Several stakeholders also mentioned that existing strategies in child and adolescent health and development should be identified and used instead of countries “reinventing the wheel”. They

stressed that an estimate of costs would be crucial in ensuring political commitment and a stable and adequate allocation of financial resources. A costing tool was suggested by several participants, together with detailed action plans to tailor the costing tool according to the future actions that national strategies would imply.

Integration was regarded as an intersectoral matter. The creation of a stable working group that coordinates the process is essential, with consistent membership over a long time scale. It was also crucial to select representatives who are high-level decision-makers and, at the same time, ensure that they hold positions that do not frequently change following elections and restructuring within ministries. To select such a group and turn it into a fixed structure in which representatives do not change from one day to the next is not an easy task, and ongoing reforms in the countries are impeding progress to a great extent. One of the essential tasks of the working group would be to identify and map the documents within each sector that correspond to different parts of the strategy for child and adolescent health and development and integrate the information into the strategy. This would prevent overlapping and contradictory elements between strategies.

Evaluating the strategy

Evaluating national strategy development and implementation processes should be carried out in several ways.

Evaluation requires the identification of desired outcomes and monitoring of the strategy. According to the participants at the workshop, it is vital to define indicators that allow benchmarking and, at the same time, set realistic deadlines during the process of developing and implementing the strategy. The process should be broken down into short-term goals that enable stakeholders and, most importantly, politicians to perceive progress before any health outcomes can be detected in the population. Whether this need should be met by the development of an evaluation tool or in a different way (for instance, by developing an indicator framework in which different sections can be added according to the stage of the process) was not agreed upon by the participants.

It was considered important to evaluate the process to obtain greater and continuous political commitment. Part of political commitment should be ensured by creating the possibility of benchmarking between countries and perhaps between different sectors within countries.

The comparison between country situations was perceived as being extremely motivating and a useful tool for action. Another important aspect of the evaluation is to be able to learn from the experience of countries that have already gone through certain political and professional trends and developments that are now commencing in other countries.

Overall, workshop participants demonstrated great commitment towards the development of national strategies based on the European Strategy. The two-day workshop proved to be a valuable space and an opportunity to confront common challenges, share strategic information and propose possible solutions for national strategies on child and adolescent health and development.

Conclusion

This concluding section is based on findings emerging from the analysis of information gathered through the case study questionnaires, narratives, individual interviews and roundtable discussions. It will pay particular attention to the lessons learnt, the added value of the *WHO European strategy for child and adolescent health and development*, the main common challenges and the country requests for WHO efforts in relation to national experiences in developing and implementing specific strategies in this field.

The five countries – Albania, Armenia, Hungary, United Kingdom (Scotland) and Uzbekistan – have different historical, political, economic and social contexts that have influenced their priorities in the formulation of national strategies. This means that while all the national strategies are inspired by the guiding principles and values of the European Strategy, there are significant differences in their approach and contents.

Lessons learnt

Political commitment

In general, verbal commitments have been made and are regarded as high in all case study countries, but commitment to action is low. Stakeholders saw significant differences between verbal commitment (policy) and practical commitment (action). Ongoing health reforms in some of the countries are also influencing the degree of political commitment. Stakeholders emphasized that lack of resources and the continuously changing political environment and priorities are the main reasons for limited commitment to concrete actions.

The guiding principles

Participation

Actors in all countries agreed that young people should be involved in the development of the strategy, but direct participation of young people and/or their parents is not considered sufficient in any of the countries. NGOs and other sectors have good experience within the field and could provide an entry point for better youth participation. The NGO situation in the five countries is extremely diverse. Each country has different characteristics in relation to the extent to which NGOs exist and the way they are involved in national processes.

Based on the findings, it is possible to conclude that NGOs can contribute to the development of the strategy in different ways and can be regarded as an extremely useful resource in the implementation phase. NGOs can be advisers to decision-makers, direct contributors in the development process, and “watchdogs” who ensure that the interests of the population are represented. Direct involvement of NGOs is limited in most of the countries, mainly due to national traditions and/or mistrust of NGOs and their ability to contribute to the process in a constructive way.

Life-course approach

The life-course approach is perceived in all countries as a good way of ensuring that all age groups are taken into consideration. Most programmes tend to focus on children's health and do not address adolescents' health sufficiently. In future, national strategies should include the life-course approach to increase attention towards this age group.

Equity

Territorial differences were regarded as an important aspect of inequity. Different at-risk population groups were regarded as having particular problems that need to be addressed in a national strategy for child and adolescent health and development. The concept of gender is starting to become recognized and incorporated in different policies and actions. In Albania, for example, a gender strategy has recently been approved, and a gender analysis was carried out in relation to the development of the reproductive health strategy in Uzbekistan. It was emphasized, however, that gender expertise is absent in most of the countries. The presence of gender issues among children is still not acknowledged; addressing gender issues within the area of child and adolescent health is therefore challenging.

Intersectoral action

A multisectoral working group has been established in most of the countries in relation to developing national strategies for child and adolescent health and development. Changing political environments, however, affects the stability of the groups. As a consequence, intersectoral actions are often based on informal relations, or eventually cease to exist.

Stakeholders generally regarded intersectoral collaboration as unsatisfactory. Strategies should introduce a systematic approach with clearly defined tasks for each sector to enhance intersectoral collaboration. The strategy development process is therefore perceived as a potential catalyst for intersectoral action on child and adolescent health and development in the countries.

Improving health systems

Stewardship

Priorities are often influenced by international and national agendas and by the availability of funding. Defined priorities need to be flexible to be adaptable to changing circumstances. Priorities should be evidence-based (which is not always possible because of the lack of reliable information), but also need to reflect available expertise within the country.

Financing

Financial allocations for health are increasing in all the countries apart from Hungary. The main problems with financial health expenditure are the inappropriate allocation of resources and the fact that national strategies do not have a budget to cover overall programme implementation; frequently, only specific actions have allocated funds, with no guarantee of continuity. There is consequently a strong wish for guidance and technical support on cost-efficient allocation of financial resources.

Another important factor is informal payments within the health services, which seem to emerge due to insufficient financial resources and lack of transparency in provision of health services.

Health services

There is unequal geographical distribution of health professionals and facilities within most of the countries. Transition periods and consequent ongoing health reforms in some of the countries have had a negative impact on the provision of child health care. Stakeholders referred to children being treated as “little adults” instead of receiving specialist paediatric care. Training activities need to be unified and carried out on an equal and regular basis.

Quality and coverage of health services needs thorough monitoring and evaluation according to standardized guidelines. The strategy should contribute to the improvement of child and adolescent health care by: ensuring adequate information on the provision of care; emphasizing the need for equality of care; and promoting children’s rights to health, as defined in the CRC.

Information systems

Low reliability of child and adolescent health data is a common problem in all case study countries. Consequently, planning is rarely evidence based. Low reliability of data is mainly due to inadequate collection mechanisms. Findings indicate a strong need for a unified approach to the collection and analysis of child and adolescent health information. This requires a streamlining of national and international mechanisms.

Conventions and declarations

There is a strong commitment in most countries to achieving the MDGs, although they are not considered very relevant in Hungary and Scotland. The goals are perceived to play an important role in the development and implementation of the strategy. Stakeholders also emphasized the need to ensure that the CRC is respected within the health sector. Addressing the MDGs and the CRC explicitly is not viewed as necessary, as long as strategies are in line with their principles.

Main challenges

From the analysis, various common challenges for all case study countries were identified: closer collaboration between sectors is required in all countries; and co-ordination mechanisms between different stakeholders need to be in place to create a clear definition of work tasks for each stakeholder in relation to the development and implementation of national strategies.

Making goals, priorities and action plans realistic and complementary to the needs of the population is also a challenge that requires close involvement of civil society and, in particular, of young people. It was emphasized that NGOs in all countries have substantial experience in relation to youth participation, which can be a great asset. It is also a general challenge to orientate implementation of strategies towards a central value of public health. Currently, the health promotion aspect within the development and implementation of strategies meets much resistance within most stakeholder groups. Since this value is paramount in making the approach crosscutting and intersectoral, the public health debate needs to be stimulated within working groups to achieve comprehensive understanding and consensus in relation to the principles of the strategy.

The adaptation and contextualization of the European Strategy to national circumstances is seen as an essential task for all countries developing national strategies on child and adolescent health and development.

Other key challenges include:

- ensuring long-term verbal and factual political commitment;
- paying more attention to adolescent health in national strategies;
- addressing at-risk population groups through an intersectoral approach;
- addressing gender issues in a systematic way within the area of child and adolescent health and development;
- introducing a systematic approach to enhance intersectoral collaboration;
- taking into account population needs *and* feasibility of interventions when setting priorities;
- ensuring cost-efficient allocation and resource creation for national strategies;
- improving monitoring and evaluation mechanisms within health services;
- creating a unified approach for collection and analysis of child and adolescent health data;
- managing and measuring the CRC in the everyday work of health professionals; and
- using the opportunity to link the strategy to the MDGs.

Country requests for WHO efforts

During the analysis of information collected through tools used for the case studies, information emerged that could be of use to the Regional Office in its efforts to improve child and adolescent health and development in the WHO European Region. In particular, the following needs seemed to be crosscutting:

- active involvement of WHO in supporting the development and implementation of national strategies;
- development of tools for cost assessment and monitoring and evaluation of national strategy implementation; and
- collaboration with other partners (both national and international) in the creation of consensus on what kind of data are needed and on the mechanisms for data collection.

Added value of the European Strategy

All of the case study countries have specific challenges in the field of child and adolescent health and development. The principles, goals and priority areas identified in the European Strategy are relevant to their different contexts. Countries may find the European Strategy useful for different reasons; what emerges from the present case studies is that the strategy was essential in:

- increasing attention on all age groups through the life-course approach, as child and adolescent health and development policies often tend to concentrate on specific age groups at the cost of others;

- acting as a catalyst and driver for multisectoral action in the field of child and adolescent health and development by giving stakeholders a common task; and
- advocating strongly for high-level commitment to child and adolescent health and development in countries developing national strategies.

The case studies also revealed when the European Strategy does *not* add value to the process of development and implementation of national strategy. Specifically, the monitoring process showed that the European Strategy should not be used as a document providing direct answers to national problems; it should be adapted and contextualized to the different realities of individual countries. The tools should provide help, but do not offer solutions to every existing challenge.

In practical terms, it was also seen that it is necessary for the national strategy to be accompanied by a detailed budget and action plan. Participants during the workshop mentioned that it might be useful to have an implementation framework, such as that which the European Strategy may provide, to attract funds from national or international partners. It is also essential that a small group of health professionals and decision-makers are not the only participants in the development of the strategy: stakeholders should represent different expertise, governmental and nongovernmental organizations and geographic areas. Last but not least, the direct participation of young people and their parents is crucial.

The WHO Regional Office for Europe

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