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Progress reports on Investing in Children: the European Child and Adolescent Health Strategy 2015–2020 and the European Child Maltreatment Prevention Action Plan 2015–2020

These reports provide an overview of implementation of Investing in Children: the European Child and Adolescent Health Strategy 2015–2020, and the European Child Maltreatment Prevention Action Plan 2015–2020, in line with resolution EUR/RC64/R6.

This document is submitted to the 68th session of the WHO Regional Committee for Europe in 2018.

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Progress report on Investing in Children: the European Child and Adolescent Health Strategy 2015–2020

Background

1. In 2014 the 64th WHO Regional Committee for Europe (RC64) adopted the European Child and Adolescent Health Strategy 2015–2020 and the European Child Maltreatment Prevention Action Plan 2015–2020 in resolution EUR/RC64/R6. The resolution urged Member States:

(a) to improve the health and well-being of infants, children and adolescents and reduce the burden of infant, child and adolescent ill health, including that due to maltreatment and other adverse events in childhood, ensuring actions for health promotion, health protection and disease prevention and studies on the determinants of child health and well-being, combining universal and targeted measures, with a special focus on vulnerable groups;

(b) to respect the rights of children, promote their social inclusion, offer equitable opportunities for attaining the highest quality of life and invest in interventions that support early childhood development, growth during adolescence and nurturing family and institutional settings; and

(c) to strengthen health systems and preventive services to allow access to a continuum of high-quality care, from the antenatal period through infancy, childhood and adolescence, to ensure better health and social outcomes.

2. The resolution requested the Regional Director to report back to RC68 and RC71, in 2018 and 2021 respectively, on implementation of both the Strategy and the Action Plan. This report provides information on implementation of the European Child and Adolescent Health Strategy up to 2018.

Child and adolescent health in the European Region

Country profiles

3. By compiling available information on child and adolescent health in individual Member States in the WHO European Region, with a focus on the priorities set out in the Strategy, the Secretariat has established a set of country profiles. These are publicly available through the WHO European Health Information Gateway and can be downloaded individually in pdf format.[1]

Baseline survey

4. The country profiles are complemented by the results of a survey, which was sent to Member States in 2016, with a closing date for responses of 31 March 2017. A total of 48 Member States responded within the deadline. The survey results are also available through the European Health Information Gateway, as well as in a detailed report which includes the country profiles. Responses pertaining to how national policies are aligned with the regional Strategy have been included in this summary progress report. The Annex to the

[1] See https://gateway.euro.who.int/en/datasets/cah/.

present report contains maps showing responses, by country, to selected questions asked in the survey of Member States on the topics reported herein.

Child and adolescent health strategies and governance

5. In 36 of the 48 Member States that responded to the survey, national child and adolescent health strategies have either been adopted since 2014 or are in preparation. Twelve of the existing strategies and seven of the planned strategies are standalone strategies specific to child and adolescent health. Fig. 1 in the Annex to this report compares these data with information gathered through a similar question included in a survey that the Regional Office conducted in 2006, when 18 of 34 respondents had a child and adolescent health strategy, four had a "partial" strategy, and eight did not have one at all.

6. Of the countries with a strategy in place, 20 have allocated budgetary resources to its implementation and 21 have set up monitoring systems. There are 10 countries either with a strategy or with a strategy in preparation, which do not have systems in place for monitoring its implementation against targets or indicators. In 29 Member States, there are plans to review the existing strategy by 2020, thereby providing an opportunity to influence their national child and adolescent health landscape.

Collecting key data

7. Thirty-five Member States reported that they disaggregate data on the coverage of major interventions by sex and 30 disaggregate by geographical distribution. Analysing coverage data by migrant status, ethnicity or socioeconomic background is less common; 13 of 39 countries analyse by migrant status, 11 by ethnicity, and 19 by socioeconomic background. There are noticeable regional gaps in the collection of data on all children, with only 9 of 43 countries collecting data on the health services provided to children belonging to at-risk groups (such as Roma or minority children) and 15 out of 44 countries collecting data on the health status of refugee and migrant children. Thirty-four Member States provided numbers on minors in institutional care. Although 30 countries reported that they conduct surveys on child maltreatment, children themselves are not often asked to provide information. Sixteen of 46 countries undertake nationally representative surveys on sexual or intimate partner violence, while 18 out of 46 countries collect data on maternal alcohol consumption.

Health systems and quality of care

8. The way in which health systems provide care for children and adolescents varies across the Region: Twenty-one out of 50 Member States reporting on this have mixed care systems where both a general practitioner and a paediatrician provide primary care, while in 10 countries paediatricians alone provide primary care for children. Professional staffing levels for health care for children and adolescents varies markedly between urban and rural settings, and 23 out of 43 countries reported collecting information in that regard. Eleven of 39 countries stated that they do not have a system in place to ensure continuing professional education on adolescent health. Sixteen countries reported that they do not perform regular perinatal death audits. Essential drugs lists and paediatric formulations for essential drugs are not available in 25 and 21 countries, respectively. Twenty-two countries reported that they collect information about the number of drug prescriptions issued to children and adolescents under 18 years of age, while 21 countries stated that they do not collect such data.

Rights and participation

9. Of the total of 48 respondents, 34 reported having an ombudsman with a mandate for children's and adolescents' right to health, and all reported that health has been a consistent part of their reporting under the United Nations Convention on the Rights of the Child. Children and young people are not consulted in the review, development, or implementation of the national child and adolescent health strategies in 14 of 35 countries, and their participation in these processes varies. Policies on assent, confidentiality and consent exist in 36 out of 42 countries, while access to care without parental consent exists in 37 out of 45 countries. Fewer countries reported on young people's right to have access to contraception or abortion without parental consent; 32 out of 42 and 23 out of 44 countries, respectively, reported having such policies in place. Twenty-one out of 33 countries reported the systematic collection of information on children's and adolescents' knowledge on sexuality.

Health in schools

10. All 48 respondents reported having supporting policies for early childhood development, and 28 of 44 countries reported having policies in support of health promotion in schools. Thirteen out of 42 countries reported that their national school policy does not include adolescent mental health, 20 out of 48 countries have no policy on the availability of unhealthy foods at school, and 26 of 42 countries offer sexuality education at both primary and secondary school levels.

Risk-taking and exploratory behaviours

11. The Regional Office's Health Behaviour in School-aged Children survey provides insights into the risk-taking behaviours of adolescents, with the most recent data being from 2013–2014. Accordingly, tobacco and alcohol use among adolescents are prevalent in the Region. Cannabis use is more prevalent in the European Union than in eastern Europe, central Asia and the Balkans. Bullying and fighting are particularly prevalent for 15-year-old boys in countries of the Commonwealth of Independent States. Two in five girls and one in three boys across the Region report having unprotected sex.

Mental health and well-being

12. Twenty-eight out of 43 countries reported having a mechanism in place to assess the quality of mental health services for children and adolescents, with 25 reporting that they have guidance in place for facilitating the transition from child to adult mental health services. Sixteen out of 45 reporting countries do not have community services available to provide early intervention for young people for the first episode of a mental health problem. Data on the number of child and adolescent health practitioners dealing with attention deficit hyperactivity disorder (ADHD) and autism, as well as on the number of children being treated by a mental health professional for those conditions, were only available for 18 countries with regard to ADHD and 20 countries for autism.

Infectious diseases and environmental health

13. Immunization against rotavirus was reported by eight countries. Human papillomavirus vaccines are available free of charge in 27 out of 46 countries. Treatment rates for pneumonia in children under five years of age have been reported by 22 countries. Most countries

reported that over 90% of their population have access to hygienic water supply and sanitation facilities.

Nutrition and physical activity

14. Forty-two out of 46 countries reported having a policy in place to initiate exclusive breastfeeding. Exclusive and partial breastfeeding rates vary widely across the Region. Only 10 out of 46 countries report collecting data on the marketing of complementary feeding products for infants. Marketing to children is not effectively regulated in 26 out of 40 countries, and high childhood obesity and low physical activity rates abound throughout the Region. Twenty-nine countries reported that they collect data on soft drink consumption, while 18 countries reported that they do not.

Reporting back to countries

15. All of the data above are publicly available through the Regional Office's Health Information Gateway. Specific country feedback reports have also been prepared and shared with country representatives during country visits, or during visits of country delegations to the Regional Office. The country feedback reports provide summaries of country-specific achievements in the area of child and adolescent health and possible areas for action.

Collaborating centres

16. The WHO collaborating centres for child and adolescent health in Germany, Ireland, Italy, Norway, the Russian Federation, Switzerland and United Kingdom of Great Britain and Northern Ireland (Scotland) have contributed significantly to the implementation of the European child and adolescent health strategy. Since the strategy's adoption, centres working on child and adolescent health in the Region have met three times to discuss and contribute to aspects of the monitoring process, and to develop guidelines and tools for national strategy development and implementation. Those meetings took place in 2016 in Copenhagen, Denmark, and in 2017 and 2018 in Edinburgh, United Kingdom.

Support for the development and implementation of national child and adolescent health strategies

17. Several governments have requested and received support from WHO for the development of national child and adolescent health strategies. These include the governments of Armenia, Cyprus, Republic of Moldova, Romania, Tajikistan and United Kingdom (Scotland).

18. Tools to support the preparation of national strategies have also been developed with input from WHO collaborating centres. A document detailing the national strategy development process, which was produced following a technical meeting in October 2016, is currently being field tested in Romania. This new tool integrates aspects of the materials developed under the previous European child and adolescent health strategy, which have been updated in line with the new framework. Individual tools (assessment, information, action and rights-based) have also been maintained, since these address specific aspects of the strategy process and can help Member States examine certain areas in more detail.

19. In 2015 an intercountry capacity building workshop was held on strategic planning and costing of national maternal, child and adolescent health strategies using the OneHealth tool. Country delegations have received training on how to use the tool for costing national plans on child and adolescent health.

Case studies

20. Country case studies have been conducted in Armenia and United Kingdom (Scotland), both of which have a national child and adolescent health strategy in place. The studies provide information on the strategy development process, which will inform future work in these and other countries.

Data collection on adolescent health behaviours

21. The WHO collaborative study, Health Behaviour in School-aged Children, has been collecting data and providing insight into adolescents' well-being, behaviours and social context for over 30 years. Since the adoption of the European Child and Adolescent Health Strategy, four new Member States have joined the study and others have expressed an interest in participating. Orientation meetings have been held to support countries (Azerbaijan, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Serbia, Tajikistan and Uzbekistan) with decision-making and capacity building. These efforts aim to facilitate explicit and systematic data collection on health behaviours among adolescents, and to inform policy and programme development. A new round of the survey is currently under way.

School health promotion

22. In December 2016 a high-level conference was held in Paris, France, to strengthen intersectoral cooperation between the health, education and social sectors for better and more equitable health and social outcomes for children and adolescents. The school setting was acknowledged as being essential for developing a healthy generation, and the conference declaration called for governments to make every school in the Region a health-promoting school.

23. The WHO-associated Schools for Health in Europe network also aims to make schools health-promoting settings. In 2016, 12 countries in eastern Europe and central Asia developed national road maps with a focus on noncommunicable disease prevention in and through schools. National Schools for Health coordinators in those countries took stock of Schools for Health implementation and incorporated activities on health-promoting schools into meetings organized by the WHO Collaborating Centre for Improving Services for Children in Moscow, Russian Federation, in 2016 and 2017. School health approaches were piloted and supported by WHO in Azerbaijan, Kazakhstan, Republic of Moldova, Ukraine and Uzbekistan.

Other strategies and action plans

24. The 2030 Agenda for Sustainable Development and its accompanying Sustainable Development Goals were adopted in 2015. The Regional Office mapped the European Child and Adolescent Health Strategy against that framework.

25. After the launch of the European Child and Adolescent Health Strategy, several strategies and action plans were published at the global level that addressed issues related to child and adolescent health. In 2016 the Global Strategy for Women's, Children's and

Adolescents' Health (2016–2030) was adopted, of which child and adolescent health is an integral part. In line with that Strategy, Global Accelerated Action for the Health of Adolescents (AA-HA!) was launched in 2017, providing guidance for implementation at the national level of measures in support of adolescent health. A regional adaptation of AA-HA!, supported by the WHO Collaborating Centre for Health Promotion and Public Health Development in Scotland, United Kingdom, has been developed to assist European countries in designing and implementing national plans in response to the health needs of adolescents.

26. A stronger focus is being placed on early childhood development, with guidance being provided by the nurturing care framework. A progress report on the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) that was noted by the Seventy-first World Health Assembly in May 2018 (document A71/19 Rev.1) also updated Member States on developments with regard to the nurturing care framework.

Conclusion and way forward

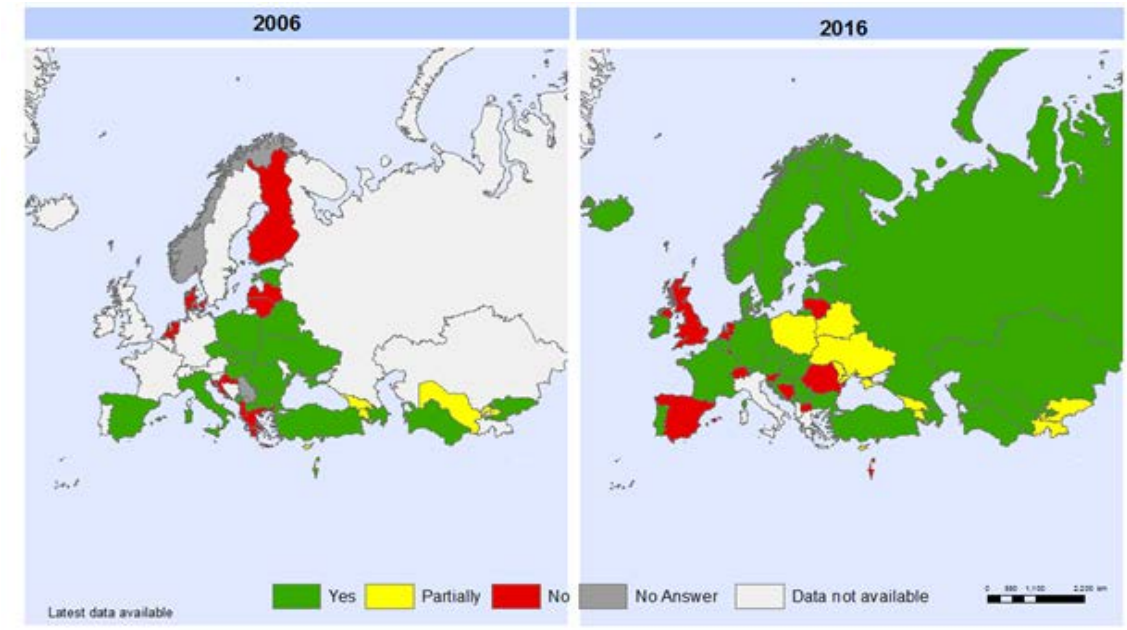
27. The information detailed in this report is publicly available through several means, most conveniently through the Regional Office's Health Information Gateway. It should inform decision-makers about gaps in their national approaches to child and adolescent health and well-being, which they might wish to review and address. WHO stands ready to support Member States in this effort. As mandated by the Regional Committee, a further progress report, together with one on implementation of the European Child Maltreatment Prevention Action Plan 2015–2020, will be issued in 2021. The Secretariat will consult Member States, in a parallel process, about the renewal of the child and adolescent health strategy for the period from 2021 onwards, and its content, in line with the Sustainable Development Goals and the Global Strategy for Women's, Children's and Adolescents' Health, which cover the period up to 2030.

Annex. Maps

1. The following maps present responses, by country, to selected questions asked in the survey of Member States on the major topics reported above.

Strategy and governance

Fig. A1. Survey question: does the country have a national strategy for child and adolescent health and development, which has been adopted in the past five years?



Collecting key data

Fig. A2. Survey question: does the country collect systematic information on the health of migrant and refugee children?

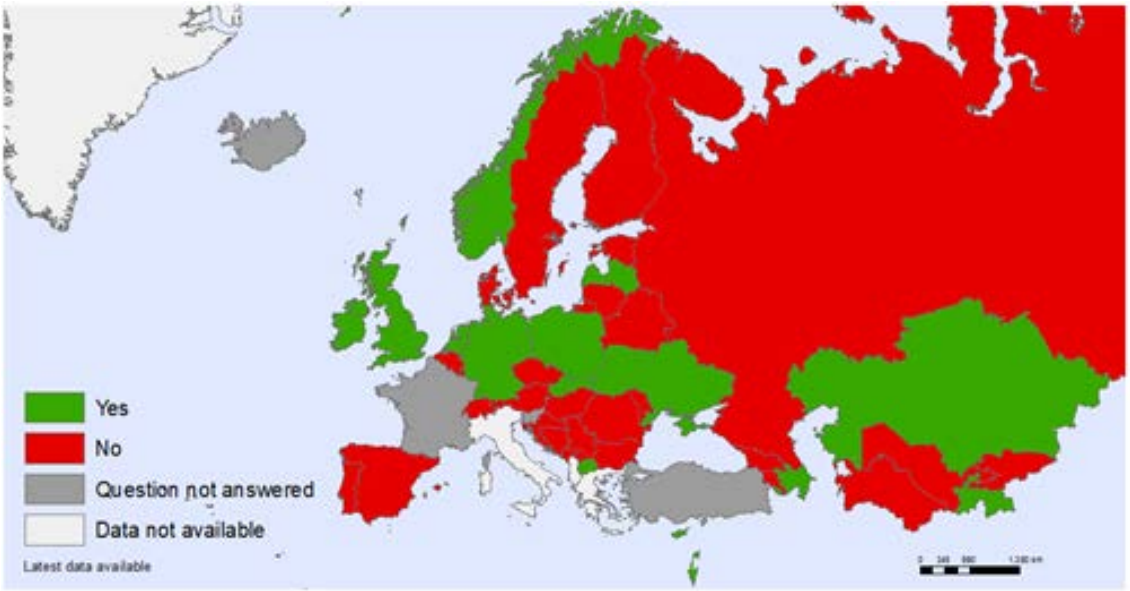


Fig. A3. Survey question: does the country keep health statistics on the health services provided to at-risk groups?

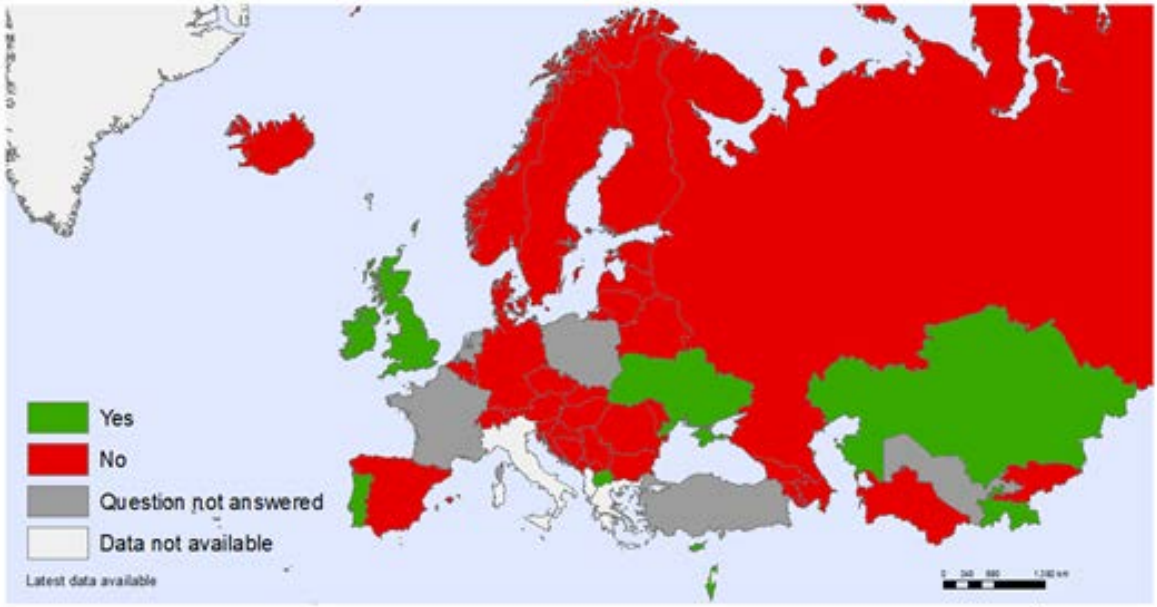
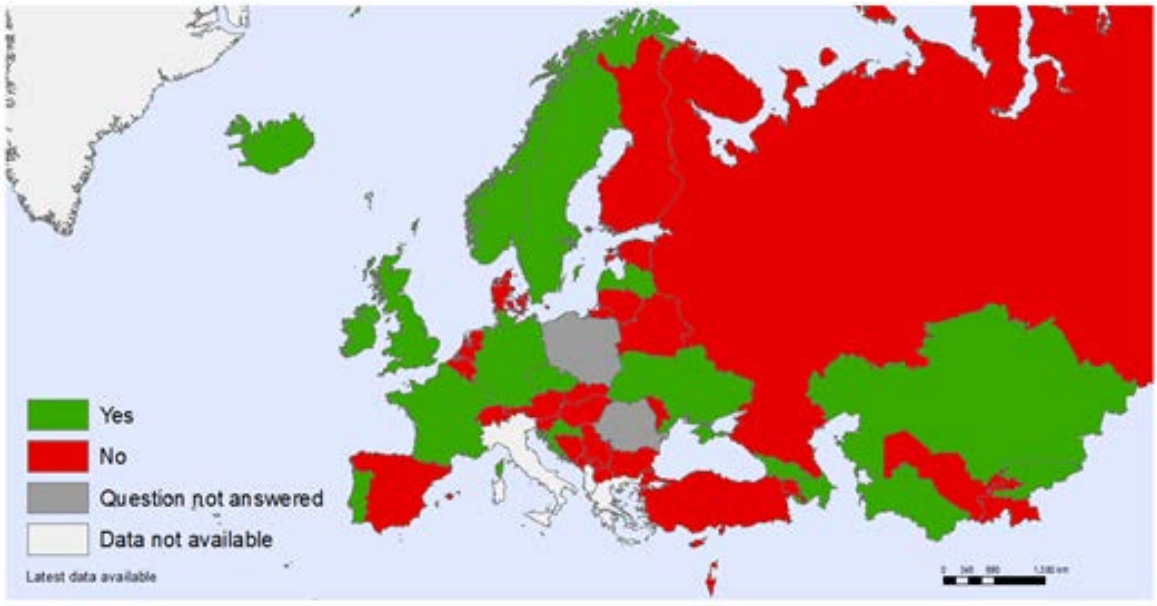


Fig. A4. Survey question: does the country collect systematic information on maternal alcohol consumption?



Health systems

Fig. A5. Survey question: does the country collect data about gaps between staffing levels for children and for adolescent health services disaggregated by urban/rural settings, capital/non-capital?

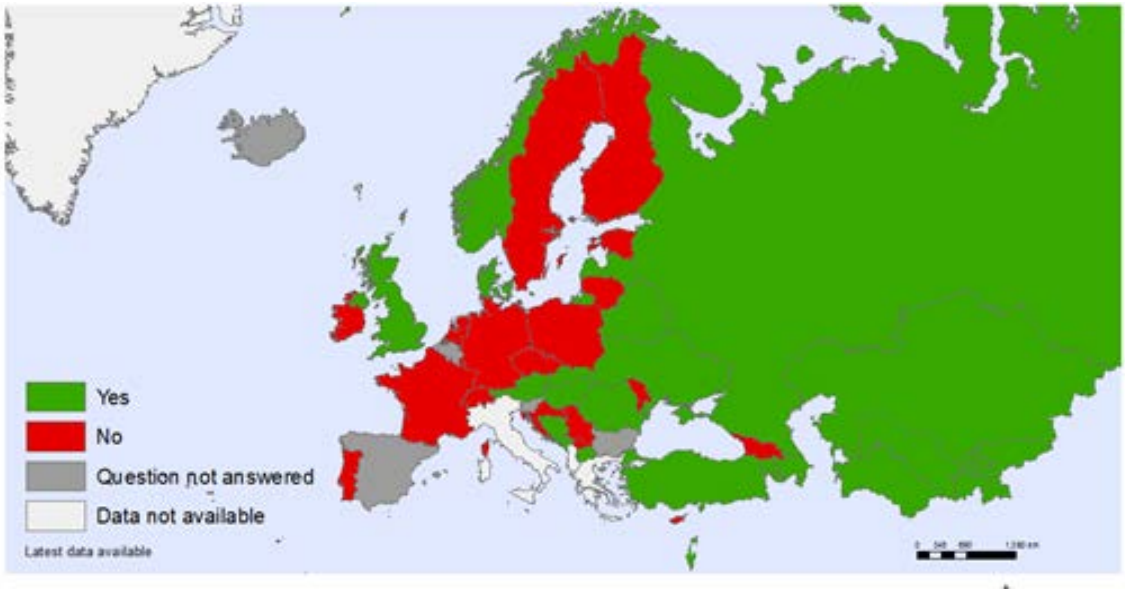


Fig. A6. Survey question: does the country have a mechanism for continuous medical education for professionals (doctors, nurses, etc.) specifically for adolescent health?

Fig. A7. Survey question: has the country adopted a paediatric essential drugs list?

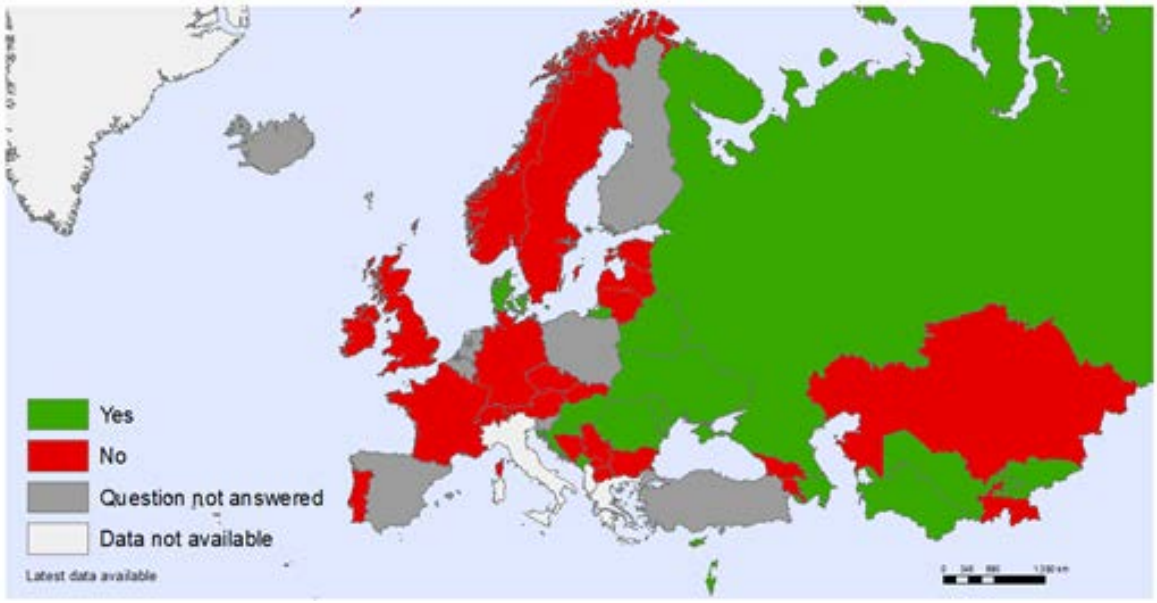
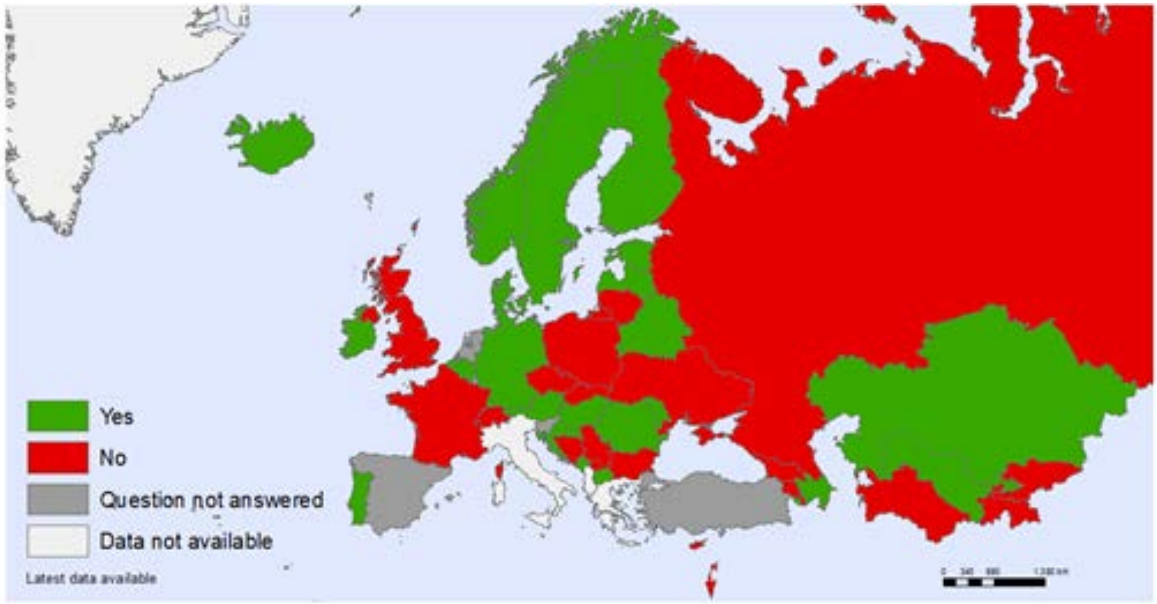


Fig. A8. Survey question: does the country collect information about the number of drug prescriptions issued to children and adolescents under 18?



Rights and participation

Fig. A9. Survey question: is there legal access in the country to abortions without parental consent for adolescents under 18?

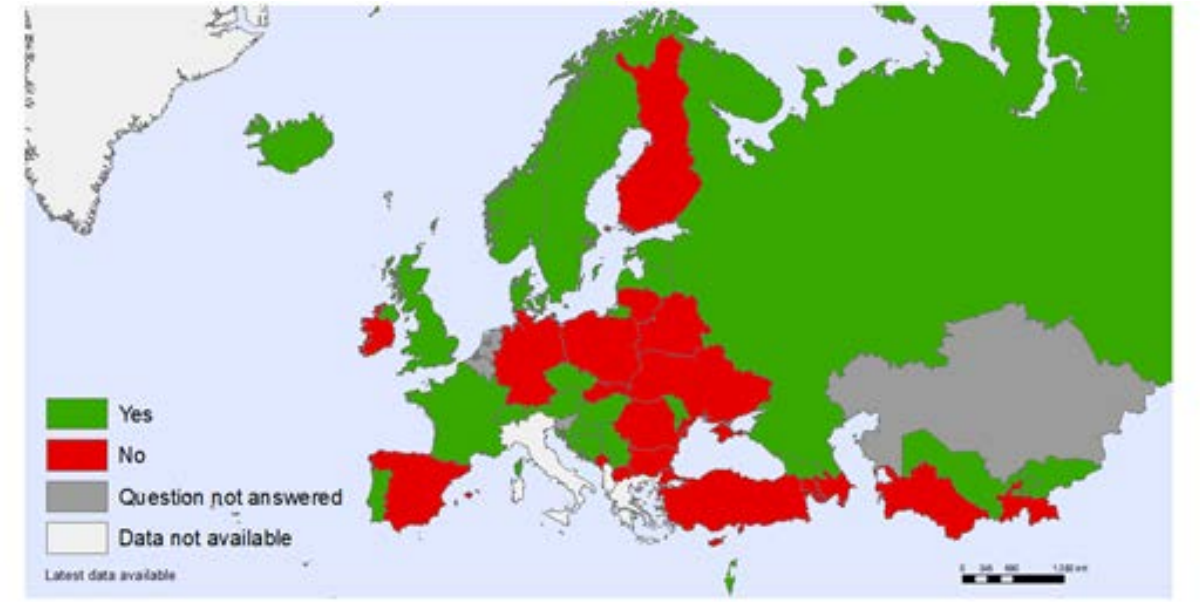


Fig. A10. Survey question: does the country collect information about children's and adolescents' knowledge on sexuality?

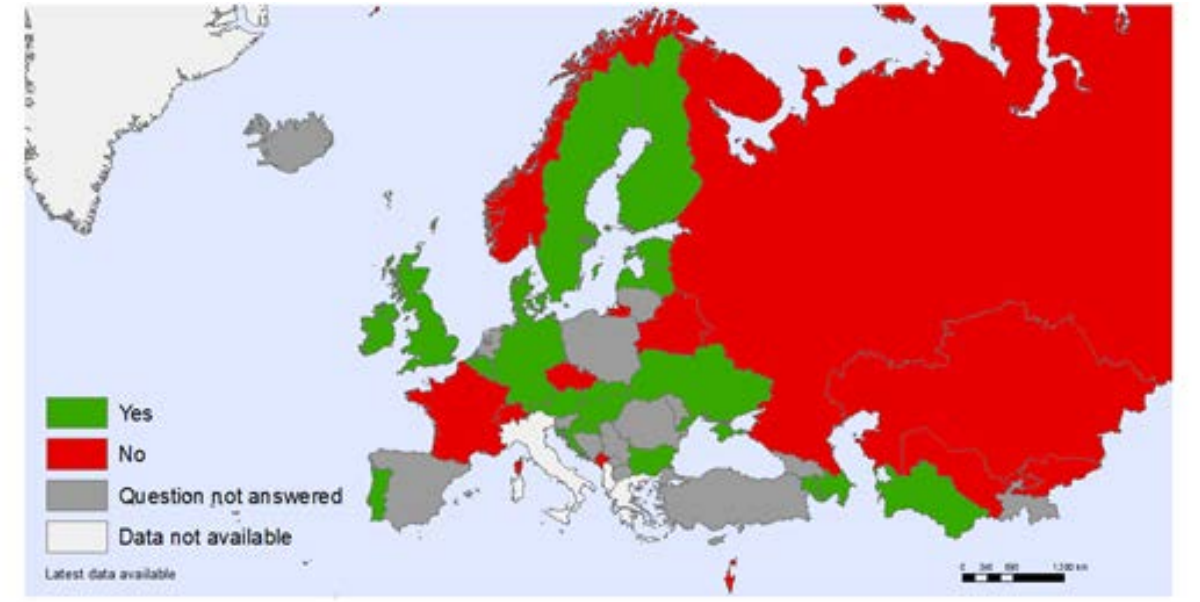
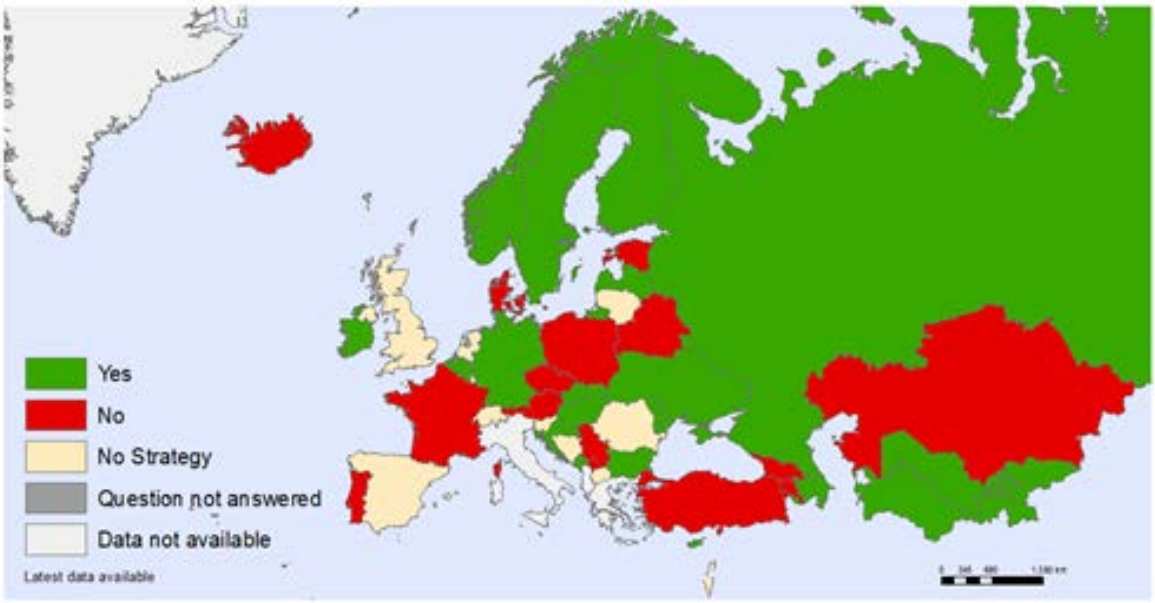
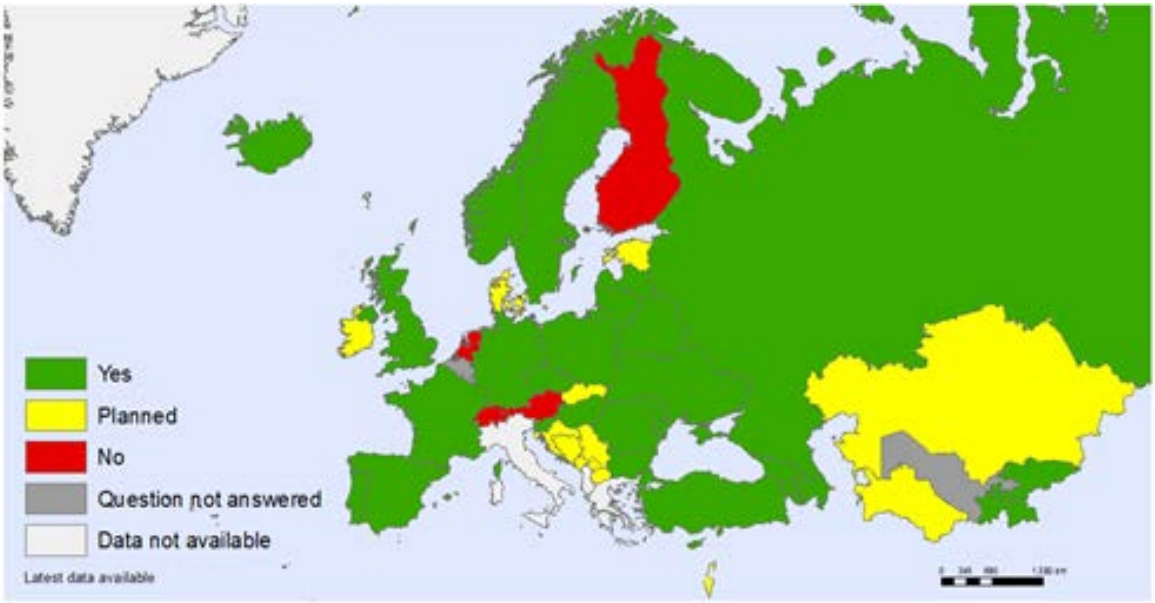


Fig. A11. Survey question: has youth been involved in the review, development or implementation of the child and adolescent health strategy in the country?



Health in schools

Fig. A12. Survey question: does the country have legislation that affects the availability of unhealthy foods in schools?



Mental health

Fig. A13. Survey question: does the country offer community services for early intervention and continuing support to young people with a first episode of a severe mental health problem?

Infectious diseases

Fig. A14. Survey question: has the country made the human papillomavirus vaccination available, free of charge, through national vaccination programmes?

Nutrition and physical activity

Fig. A15. Survey question: does the country collect data on the marketing of complementary feeding products for children aged 6–24 months?

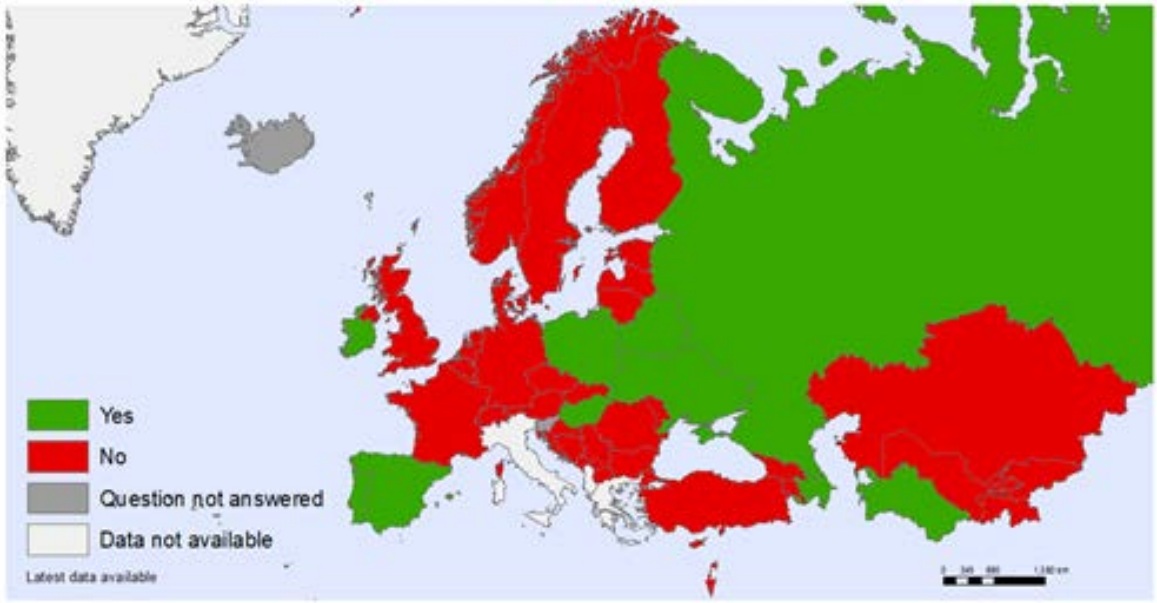


Fig. A16. Survey question: does the country collect data about soft drink consumption for children and adolescents?

Data collection on adolescent health

Fig. A17. Member countries of Health Behaviour in School-aged Children (HBSC) in 2018

Progress report on Investing in Children: the European Child Maltreatment Prevention Action Plan 2015–2020

Context

1. This report provides information on progress made in implementing Investing in Children: the European Child Maltreatment Prevention Action Plan 2015–2020 in the three years since its adoption by the WHO Regional Committee for Europe in resolution EUR/RC64/R6. The Action Plan contributes to the delivery of the vision and mission of Health 2020, the European policy framework for health and well-being.

2. In adopting resolution EUR/RC64/R6, Member States took a decisive step towards implementing the Action Plan across the WHO European Region. The goal of the Action Plan is to reduce the prevalence of child maltreatment by implementing preventive programmes to address risk and protective factors, including social determinants. The Action Plan charts the way to achieving the voluntary regional target of reducing child homicides and maltreatment by 20% by 2020. It aims to reduce maltreatment in all its forms, whether sexual, physical or emotional abuse or neglect.

3. Child maltreatment continues to afflict a billion children globally and more than 55 million children in the European Region. Prevalence of maltreatment is high in the Region: 9.6% for sexual abuse (5.7% for boys and 13.4% for girls), 22.9% for physical abuse, 29.6% for emotional abuse, 16.3% for physical neglect and 18.4% for emotional neglect. The Action Plan, which was developed to address this situation, is the first of its kind to be adopted at the regional level in WHO. Studies of adverse childhood experiences in several Member States have shown that child maltreatment and other adversity in childhood are still common, and that concerted efforts need to be made, with renewed commitment across the Region.

4. The Action Plan draws on, and is in line with, the United Nations Convention on the Rights of the Child, as well as being aligned with existing global policy frameworks, notably the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, and Sustainable Development Goal (SDG) target 16.2 on ending all violence against children by 2030.

5. Reducing violence against children is also a priority in the Thirteenth General Programme of Work, 2019–2023, and its target 16 to reduce by 20% the number of children who have experienced violence in the past 12 months, including physical and psychological violence by caregivers.

Background

6. This year marks the midpoint in the time frame for implementing the Action Plan. None of the progress reported in this document would have been possible without the commitment of Member States.

7. The Action Plan recognizes that child maltreatment is unacceptable, and that children need nurturing relationships to reach their full health and developmental potential. A failure in

this regard is likely to result in health-harming behaviour, poor mental, reproductive and physical health, chronic illnesses, such as noncommunicable diseases, and premature death. The Action Plan sets a voluntary target of a 20% reduction in child maltreatment by 2020. It proposes a series of recommendations for Member States and actions for the Regional Office through three objectives:

- make health risks such as child maltreatment more visible by setting up information systems in Member States;
- strengthen governance for the prevention of child maltreatment through partnerships and multisectoral action by developing national plans; and
- reduce risks for child maltreatment and its consequences through prevention by strengthening health systems in Member States.

8. The Action Plan is based on the following approaches, in keeping with Health 2020 and the European Child and Adolescent Health Strategy 2015–2020:

- a life-course approach;
- an evidence-informed approach;
- a health systems approach;
- a partnership and intersectoral approach;
- promotion of children's rights according to the United Nations Convention on the Rights of the Child.

9. This report describes progress made up to 2018 under each of the objectives by Member States and the Regional Office. Thus far, 49 Member States have provided information for this report by responding to a survey entitled "Countdown to 2020: Implementing the European Child Maltreatment Prevention Action Plan". Country profiles are being prepared and will be publicly available through the Regional Office's European Health Information Gateway.

Objective 1. Make health risks such as child maltreatment more visible by setting up information systems in Member States

10. Progress has been made across the Region, with 71% of the Member States that responded to the survey reporting that they have undertaken national surveys on the prevalence of child maltreatment; 12% have done this at the subnational level, and 16% have not conducted any surveys at all. Surveys are important for informing the preparation and monitoring of national child maltreatment prevention action plans. While 73% of countries have a national prevention plan, 16% of those plans have not been informed by a national survey.

11. Surveys of adverse childhood experiences have been undertaken in many countries. In 13 Member States (Albania, Czech Republic, Latvia, Lithuania, Montenegro, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, the former Yugoslav Republic of Macedonia, Turkey and Ukraine) these surveys were conducted with support from the Regional Office, and multisectoral policy dialogues were held to disseminate results and recommend next steps for preventive action. The survey results show the high prevalence of child maltreatment in those countries and the associated health-harming behaviours, thus

underscoring the policy advantages of ensuring violence-free and nurturing childhoods and thereby gaining health benefits throughout the life course. Similar surveys have also been conducted in other countries, including Iceland and the United Kingdom of Great Britain and Northern Ireland. Only a few countries have undertaken sequential surveys of a comparable methodology to determine whether prevalence rates are improving (the Netherlands and the United Kingdom).

12. Four countries introduced aspects related to adverse childhood experiences in their Health Behaviour in School-aged Children surveys, and several are considering their inclusion in the 2018–2019 survey. The Regional Office has developed a handbook to support Member States in conducting surveys on the prevalence of child maltreatment (Measuring and monitoring national prevalence of child maltreatment: a practical handbook).

13. More work needs to be done to repeat standardized surveys so that trends in the prevalence of child maltreatment in a given population can be determined.

Objective 2. Strengthen governance for the prevention of child maltreatment through partnerships and multisectoral action by developing national plans

14. Multisectoral national child maltreatment prevention action plans are in place in 77% of the Member States that responded to the survey (12% of responding countries have prevention plans at the subnational level); 71% have national protection action plans (18% have protection action plans at the subnational level); and 14% of countries do not have a prevention action plan, while 10% do not have a protection plan. A policy analysis of existing prevention plans showed that although they are multisectoral, focus on prevention and have government approval, only about a third of them have a formal budget.

15. The Regional Office has worked with governments in 13 Member States to support policy dialogues on strengthening national policy and to discuss the findings of surveys on adverse childhood experiences. Situation analyses have been conducted in eight countries (Albania, Czech Republic, Latvia, Lithuania, Montenegro, Romania, the former Yugoslav Republic of Macedonia and Turkey). These have led to the strengthening of national policies on prevention and on engaging health systems as part of a multisectoral response. Many countries, including the Netherlands, Norway, Sweden and the United Kingdom, are strengthening their health system's capacity to respond to child maltreatment.

16. To assist Member States in developing multisectoral comprehensive national action plans, the Regional Office published the Handbook on developing national action plans to prevent child maltreatment. More needs to be done to develop multisectoral comprehensive national prevention plans, which need to be properly funded to achieve their stated goals.

17. Good progress is being made in amending legislation, implementing the United Nations Convention of the Rights of the Child, and prohibiting corporal punishment in all settings, including the home, which is now the case in 62% of countries, an improvement from 47% in 2012. The prevalence of reported violent physical abuse and corporal punishment, however, is high, as is parental approval of the use of physical punishment reported in the surveys conducted in middle-income countries.[1] This strongly suggests the importance of increasing

[1] See: UNICEF Multiple Indicator Cluster Survey (https://www.unicef.org/statistics/index_24302.html).

investment in changing societal attitudes towards the use of violence, including using social marketing to change attitudes in parents and caregivers and to show the benefits of using nonviolent forms of discipline and the harm caused by physical discipline.

18. When it comes to protecting children's rights, the European Region has higher implementation of relevant laws than other WHO regions, with most countries having laws that prohibit child marriage (98%), statutory rape (96%) and female genital mutilation (76%), and many (86%) having laws that mandate the reporting of suspected child maltreatment to certain professionals. These figures represent an improvement since 2012. More work needs to be done, however, with hard-to-reach populations that condone female genital mutilation on cultural grounds.

Objective 3. Reduce risks for child maltreatment and its consequences through prevention by strengthening health systems in Member States

19. Good progress is being made in this area, with an increasing number of countries investing in prevention: 80% of reporting States implement parenting programmes and 75% implement home visitation programmes on a wide scale to support families in need; 80% reported that they offer social skills and sexual abuse awareness training in schools; and 32% reported providing training for parents on shaken baby syndrome. This represents a considerable improvement since the adoption of the Action Plan.

20. To support Member States in the implementation of prevention programmes, the Regional Office has produced a guide, Implementing child maltreatment prevention programmes: what the experts say. Further support has also been provided by hosting two Nordic–Baltic subregional workshops to exchange expertise across disciplines with regard to child maltreatment prevention programming. The Nordic Council of Ministers and the governments of Latvia and Lithuania have played a particularly important role in co-hosting these capacity-building workshops. Tailored capacity-building workshops on child maltreatment prevention, with a focus on parenting and health visitation have been held in Albania, Latvia, Lithuania and Montenegro. Health ministry focal points for violence prevention attended a global meeting in Tampere, Finland, where best practices in stopping violence against children were shared.

21. Response services in the event of child maltreatment are also well developed. Child protection services are available in 82% of the Member States that reported, and medico-legal services for victims of child sexual abuse and/or rape are in place in 67%. The systematic identification of cases of child maltreatment and their referral is only conducted in 55% of reporting countries, and only 63% provide mental health services for abused victims. As post-trauma services can improve long-term physical and mental health outcomes, it is important that capacities for multidisciplinary detection and response of child maltreatment are improved.

22. INSPIRE: Seven Strategies for Ending Violence Against Children is a multiagency collaborative toolkit which contributes to the Global Partnership to End Violence Against Children. The Global Partnership was formed in response to challenges with regard to meeting SDG target 16.2 on ending abuse, exploitation, trafficking and all forms of violence and torture against children. Three of the Partnership's pathfinding countries are from Europe: Montenegro, Romania and Sweden; Armenia and Estonia have also formally expressed an

interest in becoming pathfinding countries. The United Kingdom has a donor role in this endeavour.

Is the European Region on track to achieve the target of a 20% reduction in child homicides and maltreatment by 2020?

23. There are few countries that have conducted repeated surveys at regular intervals to monitor changes in rates of child maltreatment. Homicide data for children are more readily available, though the challenges of completeness and timeliness remain. The most recent data are from 2014 and show that inequalities in the Region persist. Homicide rates associated with assault in children aged 14 years and under are 0.32 per 100 000 in the Region as a whole, 0.26 in the European Union, and 0.47 in the Commonwealth of Independent States.

24. In the five years from 2010 to 2014 inclusive, child homicide mortality rates were reduced by 11% in the Region as a whole, 8% in the European Union, and 17% and in the Commonwealth of Independent States. The most significant decline at the subregional level was seen in the countries which joined the European Union in May 2004, with a reduction of 32%. Projections based on these trend data imply that the Region is on track to reach the target of a 20% reduction in mortality rates by 2020. Inequalities persist, however, both between and within countries, and more must be done to reach children and families in situations of socioeconomic deprivation. It is important to note that homicide rates are only a proxy measure for maltreatment, and it is difficult to say whether the maltreatment target is being met. Sequential surveys need to be conducted in more countries to determine whether maltreatment rates are truly decreasing. Although progress is being made, much more needs to be done if the indicators specified in the Action Plan are to be met.

Conclusions and future plans

25. While much work has still to be done to reach the target of a 20% reduction in rates of child maltreatment and homicides in the European Region, much has been achieved. There are many examples of exceptional multisectoral action to prevent maltreatment and violence against children, which could serve as guidance to other countries and regions.

26. Since the adoption of the European Child Maltreatment Prevention Action Plan, the Regional Office has been working on child maltreatment prevention with 40 Member States. Member States' expressions of interest in and requests for support have increased, showing their strong commitment to scaling up implementation of the Action Plan.

27. In the context of implementing the Action Plan, some of the highlights of the work of the Regional Office have been: supporting countries in conducting surveys on adverse childhood experiences, holding high-level intersectoral policy dialogues to promote the development of national action plans, developing innovative tools to support Member States in strengthening surveillance of child maltreatment, developing intersectoral national action plans for prevention, building capacity for implementing prevention programmes, and engaging sectors beyond health (such as welfare, education and justice).

28. Interest in the Action Plan needs to be matched by far greater engagement by Member States. More countries need to:

(a) undertake periodic surveys of child maltreatment and other violence against children using some of the tools that have been collated by the Secretariat to monitor the situation at the national level;

(b) implement prevention programmes, such as those highlighted in the WHO INSPIRE tool; and

(c) develop properly funded intersectoral action plans that engage the health, education, welfare and justice sectors, along with civil society, in implementation of the prevention programmes mentioned above.

29. The Regional Office will continue to implement the Action Plan in the European Region in line with Member States' activities and with their guidance. The next progress report will be presented to the Regional Committee in 2021. It is proposed that progress should be assessed in 2020, and following consultations with Member States, that the Action Plan should be updated to renew the momentum in the Region, taking into account new evidence on stopping violence against children. This would support Member States in meeting SDG target 16.2, as prioritized in the Thirteenth General Programme of Work, and would ensure that the Region maintains its position as a global leader.

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