To promote children’s health in Europe, the WHO Regional Office for Europe developed a strategy for child and adolescent health for the period 2015–20, which was adopted by all 53 European member states. The priorities of the strategy are broad and include action around supporting early childhood development, reducing exposure to violence, and tackling mental health problems in adolescence. The strategy’s implementation was monitored with a survey of 82 questions sent to the ministries of health in all member states in 2016. Responses were received from 48 countries (91% of the region). Encouragingly, three-quarters of countries have either adopted or plan to develop a national child and adolescent health strategy. However, variation exists in the adoption of key components of the regional strategy and in the collection of data. For example, access to sexual and reproductive health services is unequal across the region, and childhood obesity and mental health are key areas of concern. Such survey data helps member states and the general public review achievements and address obstacles for children and adolescents realising their full potential for health, development, and wellbeing. The survey will be repeated in 2019 to identify subsequent changes in child and adolescent health in countries across Europe.

Introduction
Commitment towards child and adolescent health has gained momentum in Europe and globally in the past decade.1–4 The WHO Regional Office for Europe has been guiding development of policy for children in the region since 2003, when it set out to launch Europe’s first child and adolescent health strategy.1 This regional framework led to action supporting child and adolescent health founded on the principles of a life-course approach, equity, intersectoral action, and participation of children and adolescents. In 2014, the region adopted a second, updated framework—Investing in children: the European and adolescent health strategy 2015–20, which was adopted by all 53 European member states. The priorities of the strategy are broad and include action around supporting early childhood development, reducing exposure to violence, and tackling mental health problems in adolescence. The strategy’s implementation was monitored with a survey of 82 questions sent to the ministries of health in all member states in 2016. Responses were received from 48 countries (91% of the region). Encouragingly, three-quarters of countries have either adopted or plan to develop a national child and adolescent health strategy. However, variation exists in the adoption of key components of the regional strategy and in the collection of data. For example, access to sexual and reproductive health services is unequal across the region, and childhood obesity and mental health are key areas of concern. Such survey data helps member states and the general public review achievements and address obstacles for children and adolescents realising their full potential for health, development, and wellbeing. The survey will be repeated in 2019 to identify subsequent changes in child and adolescent health in countries across Europe.

Key messages
• All 53 countries in the WHO European Region voted in support of the European child and adolescent health strategy
• Three-quarters of countries adopted corresponding national child and adolescent health strategies, but gaps in the coverage and the monitoring of key strategic components remain
• Access to sexual and reproductive health services is unequal across the region
• Childhood obesity and adolescent mental health are problem areas in Europe
• Actions to promote breastfeeding, regulate marketing of complementary feeding products for young children, and improve school nutrition are needed
• Data collection on childhood mental health conditions is patchy and mental health services for children and adolescents need improvement
• Investment in the collection of data on health and behaviours of at-risk groups and their access to services is inadequate and should be increased to address inequities

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methodology, maps, tables of indicators, and answers organised by country. Panel 2 details how the country profiles and survey were built, where they can be found, and how the analysis was conducted.

National strategies and governance
The European strategy sets out the regional strategic framework for child and adolescent health, which countries translate into national strategies or action plans.

Panel 1: The European child and adolescent health strategy
The strategy aims to:
- Enable children and adolescents in the WHO European Region to realise their full potential for health, development, and wellbeing
- Reduce their burden of avoidable disease and mortality
Countries will set their own objectives to meet their specific needs.
Priorities of the strategy are:
- Making children’s lives visible
- Addressing the unfinished agenda of preventable death and infectious disease
- Transforming the governance of child and adolescent health
- Supporting early childhood development
- Supporting growth during adolescence
- Reducing exposure to violence and shifting societal approaches from criminal justice to preventive and therapeutic services
- Protecting health and reducing risk
- Achieving a tobacco-free millennial generation
- Promoting healthy nutrition and physical activity
- Tackling depression and other mental health problems in adolescence
- Protecting children and adolescents from environmental risks

Panel 2: Methods
The European strategy provided the basis for the indicators used to assess progress in child and adolescent health in the region. Selected indicators in country profiles and the survey reflect the strategy’s priorities and were chosen through an iterative consultative process with experts at the WHO Regional Office and Collaborative Centres and experts in related studies. The regional office reviewed profile and survey data in country feedback reports for ministries of health to encourage dialogue about strengths and weaknesses.

Publicly available data in the European Health Information Gateway were compiled into child and adolescent health country profiles that were developed for all 53 member states of the European region. These profiles were published in 2016, graphically presenting selected indicators in two-page summaries.

A complementary survey on implementing policies and monitoring services for child and adolescent health was developed (appendix). The survey collected information on areas for which publicly available data were not available. Its 82 items were based on a measurement framework that covered three major areas: the child and adolescent health policy environment, people and capacity building, and evidence to address the 36 countries (75%) had either adopted a national child and adolescent health strategy in the past 5 years or were in the process of adopting one. Of the countries with an existing strategy, 12 countries have a stand-alone child and adolescent health strategy in place, and another seven aim to have one. In comparison, in 2006, only 22 countries (46%) either had a child and adolescent health strategy or partially had one (figure 1). In the following 11 years, four countries (Spain, Israel, Macedonia, and Romania) did not renew their strategy, four (Belarus, Kyrgyzstan, Poland, and Ukraine) went from having a strategy in 2006 to having a strategy in preparation in 2017, and two countries in the EU (Lithuania and the Netherlands) did not adopt a national strategy, in contrast to the increased uptake across Europe.

Although strategies can catalyse change, pathways for their evaluation and allocated budgets are normally required to turn vision into action. Around half the countries (26 in total) had a budget allocated, mostly Commonwealth of Independent States (CIS) countries, and nine countries (19%) did not. Absence of a budget weakens the ability of a national government to act on child and adolescent health. 30 countries (63%) had systems in place to monitor the implementation of their strategy against targets or indicators, in line with global approaches and with an explicit regional emphasis on the monitoring and evaluation of health programmes. Despite global initiatives and efforts, four countries (Czech Republic, France, Hungary, and Iceland) had strategies in place that did not have a system to monitor outcomes.
A key component of successful strategies is their ability to connect with sectors that have an effect on health. 35 countries (73%) had mechanisms in place for intersectoral planning and 13 countries (27%) did not, despite advocacy for improved intersectoral action1,6 and the multisectoral drive in the global health agenda. Evaluation of policies in terms of their effects on the health of children and adolescents supports the principle of health in all policies, which is a basic approach in Europe.17 In 2017, 39 countries (81%) considered government policies for their effects on child and adolescent health. Of those, only two countries (Poland and Sweden) stated that all their policies needed to consider their effects on child and adolescent health, and other countries mentioned policies in certain sectors only. This dearth signals an opportunity to adopt best practice in support of a whole-government approach that can maximise its potential benefits, reduce the unintended consequences, and improve a country’s capacity to address the underlying determinants of health for children and adolescents.

29 countries (60%) have plans to review their current strategy before 2020. 19 of these plans involved young people, a critical stakeholder, as part of the current strategy development, but ten did not. The degree of participation in these processes varied substantially. In the 2006 survey,15 11 countries included children and adolescents in the development of their strategy. Of those 11, six included children in the development of their newer strategy and two did not. Meaningful inclusion of children and adolescents in the development of strategies that target their wellbeing is their right, enshrined in the UN Convention on the Rights of the Child (UNCRC).18,19 Plans to review existing frameworks provide an opportunity to influence a country’s activity regarding the child and adolescent health landscape, to integrate children in these reviews, and to refocus regional energy towards the aims of the 2030 agenda.

### Data collection on vulnerable children

The UNCRC19 states that each child has the right to health and protection without discrimination. An overarching priority of the European child and adolescent health strategy is “Making children’s lives visible”,6 which underscores the importance of collecting systematic, high-quality data on all children to highlight the groups for which more or specific actions are needed. Countries cannot collect this data without collecting information on the situation and context of children that might be at high risk for mental and physical ill health due to reduced access to health care, institutionalisation, or violence.

#### Children potentially at risk or vulnerable

Identification of at-risk or vulnerable children and the services they receive is important to support their highest attainable standard of health. Nine countries (19%) kept statistics on the health services provided to at-risk groups (eg, Roma or indigenous children), whereas 34 countries (71%) did not. Although the majority of countries analysed data for major interventions by sex (35 countries [73%]) and geographic area (30 countries [63%]), analysing coverage data by socioeconomic background (19 countries...
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[40%]), migrant status (13 countries [27%]), and ethnic background (11 countries [23%]) was much less common. In the case of the latter, more than half of countries (28 [58%]) do not do it.

Institutionalised children
The family is seen as the “fundamental group of society and the natural environment for the growth, wellbeing, and protection of children”.20 Therefore, the principle underlying the institutionalisation of children, including orphaned children, those that have been displaced by war, and cases in which authorities have had to intervene due to maltreatment, is that they should be separated from family only when absolutely necessary and for as short a period as possible. In these situations, placement into foster families should be swift. 34 countries (71%) provided data on the numbers of children in institutional care (excluding foster care). When asked about the numbers of children less than 3 years of age that are in institutional care, only 28 countries (58%) provided them. The reported numbers vary widely.17

Children that experienced violence and maltreatment
Countries who ratified the UNCRC have a responsibility to ask children themselves about their experiences. Only 13 countries (27%) asked children directly as part of their nationally representative surveys on child maltreatment. Five countries do not conduct such surveys: Belgium, Finland, Georgia, Malta, and Tajikistan. 16 countries (33%) undertake nationally representative surveys on sexual or intimate partner violence that includes information on adolescents less than 18 years of age. These surveys are more common in EU15 countries than in countries of the EU13, CIS, and South-Eastern Europe Health Network (SEEHN). Two-thirds of the countries (30 in total) do not conduct this type of survey, despite research showing that the most common perpetrators of sexual violence against girls aged 15–19 years are intimate partners.21

Regional surveys
WHO encourages countries to join ongoing regional efforts, such as the Health Behaviour in School-aged Children study (HBSC)22 and Childhood Obesity Surveillance Initiative,23 to monitor child and adolescent health in a comparable manner. The HBSC, conducted every 4 years since 1983, provides cross-national data on adolescent behaviours and facilitates trend analysis nationally and internationally (appendix). Other surveys have components that contribute to the regional picture, such as those on mental health, non-communicable diseases, alcohol and tobacco use, child abuse and neglect, and intimate partner violence. Their data are used to monitor the child and adolescent health and related strategies24–27 and are available through the European Health Information Gateway (panel 3),14 which also allows cross-tabulation and link surveys. Integration of participatory methods in this type of research remains to be done, and is necessary to produce data that are meaningful to children and adolescents, that reflect their lifestyles, and are of value to policy and programmes for this age group.24 Household surveys, such as the Demographic and Health Survey28 and UNICEF’s Multiple Indicator Cluster Survey,29 are noticeably missing from data collection. They provide systematic, population-based information on maternal and child health-related behaviours, such as immunisation, corporal punishment, complementary feeding practices, and the nutritional status of children less than 5 years of age. Their data are used for global monitoring exercises like Countdown 2030,30 but they are primarily done in low-income and lower-middle-income countries, so many European countries do not participate in them and must develop comparable means of collecting such data. Otherwise, noticeable gaps exist in the data, which are also visible in the child and adolescent health country profiles.14

Child rights
Children and adolescents have a right to form and express their views,9 which has implications for health services,12 such as access to confidential medical counselling and consent to treatment. Their access to confidential medical counselling is important for sensitive topics and disclosure of child maltreatment. In 36 countries (75%) policies were in place that provided guidance for children, adolescents, parents, and health workers on consent, assent, and confidentiality. Every country in the SEEHN group had such a policy, whereas only nine (69% of the 13 that responded) of the EU15 countries did.

National advocates
Many countries have entrusted the responsibility to protect the rights of children and adolescents to nationally
appointed officials. 35 countries (73%) had an ombudsman with a mandate for children’s and adolescents’ rights, of which 23 specified the mandate as children’s rights only, and seven indicated that the mandate considers a broader target population. Countries explained that the ombudsman’s responsibilities included the promotion, protection, and monitoring of children’s rights, as well as the mediation of breaches of them, representation of children in court, raising awareness of specific rights, and other administrative responsibilities. 15 of the countries with an ombudsman involved young people in the development of their child and adolescent health strategy, but 18 did not, which might indicate that a specific person in government with a mandate on children’s rights is not sufficient to catalyse change. The promotion of practical tools and the measurement of children’s and adolescents’ participation in matters that affect them can support their integration within national approaches.

Sexual and reproductive health
Article 12 of the UNCRC states that children have a right to form and express their views and have them heard in matters that include their sexual and reproductive health. Sexual and reproductive health rights also relate to the European strategy’s overall priority of “Making children’s lives visible”, specifically by transforming the governance of child and adolescent health and supporting growth during adolescence. These rights and access to services to support them are sometimes denied or restricted as a result of policies and practices across the region. These differences represent obstacles in reducing inequalities and transforming gender norms.

Access to contraception and abortion
To prevent unintended pregnancies in adolescents, free access to contraception without parental consent should be available. Legal access to contraception without parental consent for adolescents less than 18 years of age was available in 32 countries (67%). Five CIS countries, three EU13 countries, and one SEEHN country did not have legal access to contraception without parental consent (appendix). 13 countries (27%) submitted minimum ages for access, with seven of these countries setting their minimum age at 16 years of age. The minimum age in Denmark and Serbia is set at 15 years, and in Georgia and Austria it is 14 years. Eight countries (17%) have mechanisms that allow for earlier access depending on the maturity of the child. Access to abortion for those younger than 18 years without parental consent is an even more difficult issue in many countries; 21 countries (44%) do not provide legal access. An absence of access to abortions increases the risk of illegal abortions, with dangers for the wellbeing and life of the mother.

Adolescent sexuality
The sexuality of adolescents is an area in which some European governments are particularly inactive, which might reflect their discomfort with this issue or their fear of opposition. The position of the UNCRC, which all 53 governments of the WHO European Region have signed, is clear on participation and access to services. The region has also endorsed an action plan for promotion of improvements in sexual and reproductive health, especially around better access to contraception, health services for at-risk groups, and access to sexual and reproductive health services, which are unequal across Europe. Additionally, standards for sexuality education in Europe exist that provide guidelines for the introduction of holistic sexuality education in countries. These resources can support societal changes and improved outcomes for children and adolescents in countries throughout the region.

Human papillomavirus vaccination
Human papillomavirus (HPV) is the main cause of cervical cancer, causing 266,000 deaths annually worldwide. Countries should strive to include HPV vaccines in national immunisation programmes to foster immunisation coverage and to guarantee children’s right to the best possible health care. 27 countries (56%), most of which are located in the west of Europe (figure 2), have implemented free national HPV vaccination. Girls aged 9–14 years, before their sexual debut, represent the primary target group for HPV vaccination. The HPV vaccine is relatively new and rather expensive, which also poses an obstacle to extension of vaccination to secondary target groups (ie, females aged 15 years old or older or males).

Nutrition
Nutrition during childhood and adolescence provides a foundation for a healthy life course. A balanced diet and healthy eating habits promote wellbeing and protect against ill health. Our survey explored a number of issues related to nutrition and we present results on breastfeeding, soft drink consumption, and obesity, which address the European strategy’s third priority (panel 1) and provide an idea of potential areas for action in the region.

Breastfeeding
WHO recommends that mothers exclusively breastfeed infants for the first 6 months to achieve optimal growth, development, and health. Thereafter, infants should be given nutritious complementary foods and continue breastfeeding up to the age of 2 years or beyond. 42 countries (88%) had a policy in place to initiate exclusive breastfeeding. 21 countries reported specifically implementing the Baby Friendly Hospital Initiative. Wide regional variability exists in reported exclusive and partial breastfeeding rates. 40 countries (85%) collected breastfeeding data based on internationally accepted standards, and seven countries (15%) did not collect it in such a way. All CIS countries collected breastfeeding data.
following international standards, whereas almost a quarter of EU15 (23%) and SEEHN (25%) countries did not.

Marketing of complementary feeding products
Marketing of commercially available complementary foods affects the attitudes and behaviours of caregivers regarding feeding of infants or young children. It is often misleading, making unsubstantiated claims, can encourage premature introduction of complementary food or breast milk substitutes, and promote unhealthy food items.41 32 countries (67%) collected data about complementary feeding practices for children aged
6–24 months, and 15 countries (31%) did not. Only ten countries (21%) collected data on marketing of complementary feeding products for children aged 6–24 months, and 36 countries (75%) did not (figure 3). 21 countries (44%) collected information on complementary feeding practices but not on the marketing of products, highlighting a gap in the coverage of the range of practices that affect healthy nutrition in the early years.

**Soft drink consumption**

Consumption of soft drinks has been linked to obesity in children and adolescents. 29 countries (60%) collected data on soft drink consumption, and 18 countries (38%) did not (appendix). According to data from the HBSC survey of 2013–14, consumption of soft drinks in Europe varies substantially. Daily consumption of soft drinks increased with age for boys in 23 countries and, for girls, it increased with age in 16 countries. 8 of the countries that reported that they did not collect this data participate in the HBSC study, indicating that they are not aware of or do not use this data source and suggesting a disconnect between HBSC teams and staff of ministries of health.

**Childhood obesity**

Children affected by obesity and low levels of physical activity abound in Europe. A third of children aged 6–9 years in Europe are obese or overweight. 31 countries (67%) collected data on children less than 5 years of age with obesity, and 15 countries (33%) did not. According to the HBSC survey, boys have a higher prevalence of obesity than girls in almost all countries and regions at all studied ages (11, 13, and 15 years). The accumulation of poor health outcomes related to physical activity and diet among adolescents from less affluent families makes the case for targeted interventions to curb the obesity trend. Programmes that involve children and adolescents in their development and implementation can confer health benefits, especially on knowledge and behaviours like healthy eating, and are generally viewed as positive by children themselves, which is an added benefit.

In summary, exclusive breastfeeding rates remain low in Europe despite widespread policies to support it. Collection of data on the marketing of complementary feeding products could be substantially improved. Surveillance and monitoring of children less than 5 years of age affected by obesity is scarce, with pervasive inconsistency in both methods and collection. Countries need to consider the adoption and enforcement of laws and regulations that can positively affect behaviours—eg, promote breastfeeding, ban media and in-store marketing of soft drinks to children, and take health promotion in schools seriously.

**Supporting early childhood development**

The Sustainable Development Goals (SDGs; specifically Target 4.2) state that, by 2030, all countries should "ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education", making early childhood development a focus for the 21st century. 44 countries (92%) reported that they had a system in place to support early childhood development. Of these countries, 17 (39%) had a system that offers a combination of medical approaches (ie, examinations, screening, and immunisations) as well as psychosocial interventions (ie, family support, counselling, and educational support). 12 countries (27%) had a system that offered medical treatment only, and three (7%) had a system that offered psychosocial interventions only. 17 countries (35%) offered activities such as medical staff training, development of policies or action plans, provision of health visitors, development of baby-friendly hospitals, and provision of incentives to business owners to establish nurseries and daycare centres. Encouragement of multisectoral interventions that integrate nutrition, education, social welfare, and child protection, for example, will be important in supporting children’s development during these formative years. WHO and UNICEF have developed the framework for nurturing care to promote early childhood development, which has been adopted by the World Health Assembly.

**Health in schools**

Schools are a convenient means for reaching out to the majority of children and adolescents and are well placed for preventive interventions. On average, 96% of children at the age for primary school education (6–11 years of age) in Europe were enrolled in primary schools. Across Europe, the percentage of children enrolled in primary school education ranged from 89% to 99.9%, with smaller numbers observed mostly among CIS and SEEHN countries. These percentages show that SDG Target 4.1, which states that all children complete primary and secondary education (appendix), is not being met.

Health-promoting schools aim for a supportive social and secure physical environment, the development of personal health-related skills, and the provision of school health services and health education. 28 countries (58%) had a national strategy on health-promoting schools, which might reflect the perceived conflict between health and academic attainment that challenges the effective implementation of health-promoting interventions in a setting in which the primary focus is on delivering academic outcomes. However, successful implementation of health-promoting school policies, principles, and methods can enhance the learning experience and adoption of healthier lifestyles in children and adolescents. In 2017, the WHO European Region committed to making every school a health-promoting school, because they provide a unique setting in which to tackle lifelong trajectories for physical and mental wellbeing. This commitment needs to be followed through and will require better connection of research findings to schools.
School health services

School health services can provide an opportunity to promote health and provide services, especially for adolescents, because it is usually their easiest point of contact with the health system. The European framework for quality standards in school health services, which supports member states to develop school health services, advocates for nationally and regionally tailored school health policies. 43 countries (90%) had legislation, policies, or regulations that guide provision of school health services. The two countries that did not have any policy or regulations are members of the EU.

Food in schools

Foods with high sugar and fat content, particularly those high in saturated and trans fats, promote obesity. Targeted efforts to reduce their availability in schools can set an example and help to establish lifelong eating habits and are, therefore, beneficial in curbing the increasing obesity documented in Europe. 28 countries (58%) had legislation in place that affects the availability of unhealthy foods in schools, 12 countries (25%) planned to introduce such legislation before 2020, and the remaining eight countries (17%) did not have plans to introduce legislation before 2020 (figure 4).

Health services for adolescents

Adolescent-friendly services have become more prevalent in the past decade, increasing the uptake of health services by adolescents, who are known to be reluctant to access them. 44 countries (92%) offered some form of adolescent-friendly health services. Of these countries, 17 (39%) offered a combination of medical and psychosocial or preventative services (eg, medical care and counselling services), 11 (25%) offered medically-focused services only, ten (23%) offered psychosocial or preventive services, and six (14%) focused their efforts on legislation and policies to address the need for adolescent-friendly health services.

The adoption of this type of health care contributes to the achievement of universal health coverage, but its success relies on a trained workforce. 28 countries in Europe (58%) had a mechanism in place for continuous professional education for adolescent health, and 11 (23%) did not. Adolescent health, particularly counseling adolescents, could benefit from added focus, and the scarcity of continued professional training hampers health practitioners in updating their skills and practice. Despite the global advocacy around adolescent friendly health services, many countries still do not have proper training or policies in place to provide these services.

Alcohol

Enforcement of a minimum age for purchase of alcohol contributes to Target 3.5 of the SDGs, which aims to “strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol”. 35 countries (73%) described their strategy for enforcing a minimum age for alcohol purchase. 17 countries (35%) required sellers of alcohol to ask for appropriate identification for proof of age, three (Azerbaijan, Denmark, and Ireland) required that sellers provide posters clarifying who can buy alcohol, and one
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(Finland) prohibited advertising that encourages consumption of alcohol. 18 countries (38%) imposed fines, forfeiture of license, or criminal measures upon sellers of alcohol to minors. Five countries (10%; Finland, UK, Ireland, Malta, and the Netherlands) imposed fines, warnings, rehabilitation programmes, or confiscation of alcohol upon minors caught with alcohol. In two countries (4%; Ireland and Malta), fines could be imposed on parents of minors caught with alcohol. 13 countries (27%) implemented activities to support compliance to the minimum age for purchasing alcohol, including agency or police monitoring, test-purchasing or mystery shopping, funding academic research, institutionalising staff training, launching awareness campaigns, guideline and legislation development or revision, and preventive counselling for minors.

Maternal alcohol consumption
Antenatal alcohol exposure is a leading preventable cause of birth defects and neurodevelopmental abnormalities, and can cause a range of developmental, cognitive, and behavioural conditions in children.18 18 countries (38%) systematically collected information on maternal alcohol intake. The numbers varied considerably across Europe. Seven (46%) of the EU15 countries collected this information, whereas no countries in the SEEHN region did. The need for improvement in data collection in this area is clear.

Mental health
Up to 20% of children and adolescents in Europe are estimated to have some form of mental health disorder, with a large variation in estimates of prevalence across Europe.59 Half of all mental health disorders in adults start before the age of 14 years, so not addressing this public health problem will have consequences beyond childhood and adolescence.60 The availability of community services that offer age-appropriate early interventions and continuing support is fundamental to the protection and enhancement of the personal wellbeing and productivity of children and adolescents.29 29 (60%) of European countries, most in the EU15 group, have community services available for providing early intervention for children and adolescents with a first episode of a mental health disorder. 16 countries (33%) did not have these support services (figure 5).

Quality of mental health services
Besides the provision of mental health services for children and adolescents, evaluation of the quality of care is essential for their acceptability and effectiveness. Around half of the European region’s countries (28 member states; 58%) assess the quality of mental health services for children and adolescents. This raises concerns about the absence of appropriate mechanisms for safeguarding the quality of care that children and adolescents in need receive in the remaining countries. As adolescents with some form of mental health condition are moving into adulthood, a smooth transition between paediatric and adult services is necessary.61 Around half of the European region’s countries (52%) have guidance in place for facilitating the transition from child to adult mental health services, whereas

Figure 5: Countries that provide community services for early intervention for a first episode of severe mental health disorder
The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city, or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.
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18 countries (38%) do not. The availability of such guidance was particularly low in EU13 countries compared with other country groupings.

**Treatment of attention-deficit hyperactivity disorder and autism spectrum disorders**

With an estimated prevalence of 5% for ages 6–17 years, attention-deficit hyperactivity disorder (ADHD) is among the most common childhood psychiatric disorders in the European region.62 Research on autism spectrum disorders (ASD) within the European region found a mean prevalence of 0·6% for ages 2–17 years.62 However, only a third of countries (ASD) within the European region found a mean prevalence of 0·6% for ages 2–17 years.

The survey shows that improvements could still be made, because nearly half of all countries with more than a third of the population estimated as being affected every year.62 Most countries in the WHO European Region have mental health policies and legislation, and many are making progress with the implementation of community-based mental health services.25 However, the survey shows that improvements could still be made, because nearly half of all countries neither assess the quality of mental health services for children and adolescents, nor have guidance in place for the transition from child to adult mental health services.

**Discussion**

The European child and adolescent health strategy provides a regional template for countries to build from. The findings of the survey presented in this Health Policy paper and the comprehensive report,13 as well as the child and adolescent health country profiles,14 provide feedback on areas in which improvements can be made, and allow countries to compare themselves to others. Considerable differences between countries are apparent in areas such as governance, marketing of complementary feeding products, and data collection about disparities in staffing levels, as well as in child mortality, adolescent pregnancy, breastfeeding, and institutionalised children. Some of the differences stem from structural differences within countries, or differential investment in child and adolescent health (panels 4 and 5). Highlighting the results of this survey promotes a national dialogue that could lead to improvements in health. The differences also provide a chance to share best practice in the support of children and adolescents in Europe. Practical tools, such as the Global Accelerated Action for the Health of Adolescents66 and other regional tools, contribute to this improvement process. Overall, the findings demonstrate the need for further action in every country to realise the full potential of European children and adolescents. The aforementioned tools and documents should be considered when taking this action, as well as the specific feedback provided to countries. Because they are available to all stakeholders, they also contribute to an improved accountability process in countries.

**Panel 4: Adopting a national strategy in Armenia**

The Armenian child and adolescent health strategy (2016–2020) was based on the WHO European strategy, which was considered a useful guide, and integrated other international documents, such as the Sustainable Development Goals and Health 2020. Armenia is a lower-middle-income country in the Caucasus, with an under-5 mortality of 13·4 per 1000 livebirths. Emerging health threats prompted the development of the first national child and adolescent health strategy in 2006. Armenia was chosen as a pilot country for additional technical support by WHO in this effort. The development and implementation of the national child and adolescent health strategy were initiated by the Ministry of Health and led to meeting the Millennium Development Goal of reducing infant and child mortality.

Before the development of the new national strategy, a situation analysis was requested by government. Lessons from the first strategy implementation process included the need for better intersectoral collaboration and a more realistic and feasible strategy, owing to the scarcity of resources and staff. Some obstacles were difficult to address in the new process: lack of financial resources, technical capacities in some areas, lack of staff, and uncertainty about political developments and reforms. Experiences in intersectoral collaboration made clear the importance and benefits of joint work between different sectors, but also revealed the need for improved collaboration. Scarcity of staff and technical skills were mitigated by a redistribution of staff competences and training. For example, physiotherapist roles were filled by nurses with special training in this area. Many unforeseen activities were not supported by the government budget, but those that were prioritised were financed and implemented, and funding for others was sought from donors.

In conclusion, Armenia developed a strategy that tried to incrementally cover the whole area of child and adolescent health. A balance was struck between needs and the available resources; rolling out the strategy to the whole country remains a challenge.
Panel 5: Improving the health of children and adolescents in Scotland, UK

“The best place for a child to grow up” is the ambitious vision the Scottish Government set for Scotland, focusing on addressing inequalities. The country’s will to improve children’s lives, not just their health outcomes but also broader social determinants of health such as poverty and educational attainment, has resulted in a large number of policies across the domains of the European child and adolescent health strategy. For example, in 2016, Scotland adopted its first \textit{first} parenthood strategy for young people to address the strong correlation between deprivation and pregnancy in young people less than 20 years of age, and in 2017 it adopted a bill to tackle child poverty that seeks to build a framework to evaluate future action in this area \textit{(see Child Poverty (Scotland) Act (asp 6))}. This extensive policy has emerged across all areas of devolved government in the past decade, and has produced challenges in implementation that point to a need for streamlining policy affecting children to maximise resources and effects.

The Scottish Government, therefore, committed to developing a 10-year Action Plan for children’s and young people’s health and wellbeing. It provides an opportunity for a comprehensive approach to improving children’s wellbeing. The political commitment to develop a national plan will need subsequent action to see it through. The country has taken the initial steps, and will be delivering the Plan in 2018, the Year of Young People in Scotland.

Obstacles in this process can be overcome with support for countries. The WHO Europe regional office, with support from experts in Scotland, has developed a short programme review tool for member states that facilitates the adoption and implementation of a national strategy in line with the European child and adolescent health strategy. The Scottish experience has informed this work to support other countries like Romania in their strategy development. These tools and advice processes have the potential to support the development of robust, evidence-informed policy across Europe.

Strengths and limitations of the process

A limitation of the survey was its reliance on self-reporting by national ministries of health. Qualitative questions in particular, which asked for explanations and examples, were answered with differing amounts of detail and uneven quality. Review and comparison of results was, therefore, sometimes difficult. Nevertheless, we included qualitative responses because they provide further insight into the categorical questions (appendix). Where regional variation in administration of health systems exists, feedback from the ministries of health might not reflect the full picture of child and adolescent health in those countries—eg, the UK reported that it does not have an ombudsman, although every country that forms the union has one. Inconsistent understanding of a term or its translation could also have affected the reported indicator in some cases—eg, numbers of institutionalised children varied and qualitative comments in the survey showed that children were counted differently in this category. However, we refrained from changing data. We believe the inconsistencies and differences of opinion should elicit a dialogue in countries on potential improvements to data quality in preparation for the next survey round.

Health systems

Health systems for children and adolescents in Europe are diverse: some have paediatricians, and others use family physicians or general practitioners as primary providers. A major research collaboration, Models of Child Health Appraised, is compiling information on these differing systems. Both systems, and any mixture of them, have their strengths and weaknesses, but all depend on sufficient numbers of providers who have the skills to work with children and adolescents and their health conditions. Our analysis raises some concerns. Countries need to collect data on areas likely to be neglected, such as the rural–urban divide, mental health providers, skills, and continuous medical education in adolescent health, but more importantly, they must act upon them. WHO provides examples and benchmarking for countries, including for adolescent health. Addressing adolescent health comprehensively requires a systems approach that brings European medical education and practice in line with countries, such as the USA, Canada, and Australia, that have developed dedicated health-care structures and specialised training in this area.

Targets

The increasing adoption of national frameworks in Europe favours action on child and adolescent health, but a politically-endorsed response to the gaps in the data identified here is needed. For example, countries have a responsibility to facilitate children’s participation in matters of concern to them, but they find it challenging to meet this goal. Scarcity of disaggregation (eg, by ethnic background), inadequate availability (eg, treatment of mental conditions or about neglected issues like maternal alcohol consumption), or inconsistent data collection for key indicators (eg, children who are institutionalised or victims of violence) hampers national and regional abilities to address the equality gap in this age group. These matters have been included in country feedback reports, which will be used to elicit dialogue with countries about their achievements in the area of child and adolescent health and about possible areas for action. Monitoring and evaluation of identified interventions will be crucial for facilitation of improvements towards national
targets. Even when global targets exist (eg, exclusive breastfeeding or physical activity), wide variability or low rates indicate poor adherence or the need for additional interventions to meet them. Therefore, support for countries to evaluate their national strategies remains a priority to promote evidence-informed programmatic and policy changes in Europe. Collaboration around regionally relevant targets for child and adolescent health can enhance national work to address findings, align indicators with international commitments, and reduce reporting requirements for countries in the region.67-69

Progress towards 2020 and beyond
The survey will be repeated in 2019, as mandated by the Regional Committee, to document changes from what has been presented here. An analysis of findings from the survey presented here and those that will be collected in 2019 will inform the renewal of the child and adolescent health strategy for the period from 2021 onwards, in line with relevant strategies that cover the period up to 2030. These findings should inform decision makers about trends in the European region and areas in which they can affect change in their national policies in support of improved child and adolescent health and wellbeing. As we approach the European strategy’s endpoint in 2020, we stand to realise its ambitions and, with national action, advance towards achieving the 2030 Sustainable Development Agenda.

Contributors
AYA-D, SB, AK, and MWW were responsible for manuscript concept, AYA-D, SB, CNH, and MWW contributed to the panels, AYA-D to the national strategies and governance section, AYA-D and SB to the data collection on vulnerable children section, AYA-D and LLS to the health in schools section, AYA-D and KK to the health services for adolescents section, KK to the alcohol section, and AK to the nutrition section. AYA-D and LLS to the child rights collection on vulnerable children section, AYA-D and SB to the data collection on children and adolescents in conflict with the law, and AYA-D, SB, AK, and MWW were responsible for manuscript concept. AYA-D, SB, AK, and MWW contributed to the panels, AYA-D to the national strategies and governance section, AYA-D and SB to the data collection on vulnerable children section, AYA-D and LLS to the health in schools section, AYA-D and KK to the health services for adolescents section, KK to the alcohol section, and AK to the nutrition section. All authors contributed to the review processes and approved the final version of the paper.

Declaration of interests
AK and MWW are WHO staff members. The opinions expressed are theirs and do not necessarily represent the policies and positions of the World Health Organization. All other authors declare no competing interests.

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References


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