Child and adolescent health and development in a European perspective – a new WHO strategy

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ABSTRACT

In general, children and adolescents in the WHO European Region today have better nutrition, health and development than ever before. There are striking inequalities in health status across the 52 countries in the Region, however, with over ten-fold differences in infant and child mortality rates. Inequalities are also growing within countries, and several health threats are emerging. Against this background, the WHO Regional Office for Europe has developed a European strategy for child and adolescent health and development. The purpose of the Strategy, together with a tool kit for implementation, is to assist member states in formulating their own policies and programmes.

The health of children and adolescents is a resource for future economic and social development in all countries, whether they have high, middle or low income. Early investment in the health of children and adolescents is important for many reasons. First, there are moral and legal reasons to ensure children's right to enjoy the highest attainable standard of health, as embodied in the United Nations Convention on the Rights of the Child. Further, the world community has established a Millennium Development Goal of reducing the mortality of children younger than five years by two thirds in 2015 compared with 1990 in connection with the United Nation's Millennium Declaration [1]. Finally, many diseases can be prevented and health-promoting measures implemented with optimal effectiveness from the earliest stages of life.

The European Region of WHO has 53 Member States, including all 27 European Union (EU) countries and countries in central and eastern Europe and central Asia. The health status of children and adolescents in the European Region has generally improved in recent decades. Child mortality has been declining gradually in nearly all countries at different rates and especially fluctuated at the time the USSR was dissolved (Figure 1).

Nevertheless, child mortality rates and other health indicators differ substantially between countries and within each country according to socioeconomic group, ethnic group and geographical distribution. Based on this, the WHO Regional Committee for Europe, which comprises representatives of all 53 European Member States, decided in 2003 that the WHO Regional Office for Europe would develop a European strategy for child and adolescent health and development [2]. The purpose of the strategy is not to provide universal solutions to all the challenges of child and adolescent health and development but to create a platform and principles that all Member States can use to formulate better policies and programmes in this field. A toolkit was therefore developed, the strategy comprising three tools (an action tool, an assessment tool and an information tool) to be used in implementing the strategy.

HEALTH STATUS AND TRENDS

The global trends in children's health are not encouraging, as measured by the extent to which the world is currently fulfilling the Millennium Development Goals. Many countries, especially those in sub-Saharan Africa, have stagnating or even increasing child mortality.

The trend is mixed in the European Region. Infant mortality has declined substantially in the past decade in the 15 countries that were EU members before 2004 and, to a lesser extent, the 12 EU newcomers (Figure 1). This has been achieved despite a low initial rate of infant mortality and no intervention specifically targeting reducing child mortality besides the general progress in treating and preventing the diseases of childhood and health problems in infancy. In contrast, several countries of the former USSR, especially the central Asian republics, have a less positive situation. Child mortality increased in several countries in connection with the dissolution of the USSR, and the rates have declined moderately since then or stagnated. Several of the countries will not be able to fulfil the Millennium Development Goal on child mortality if this situation is not changed [3, 4]. The actual child mortality in these countries is even higher than the official statistics because of missing and incomplete reporting of child mortality and differences in the definition of the criteria used to decide whether an infant is classified as born alive.

A consistent theme for child and adolescent health and development is the inequality and differences between countries in the Euro-

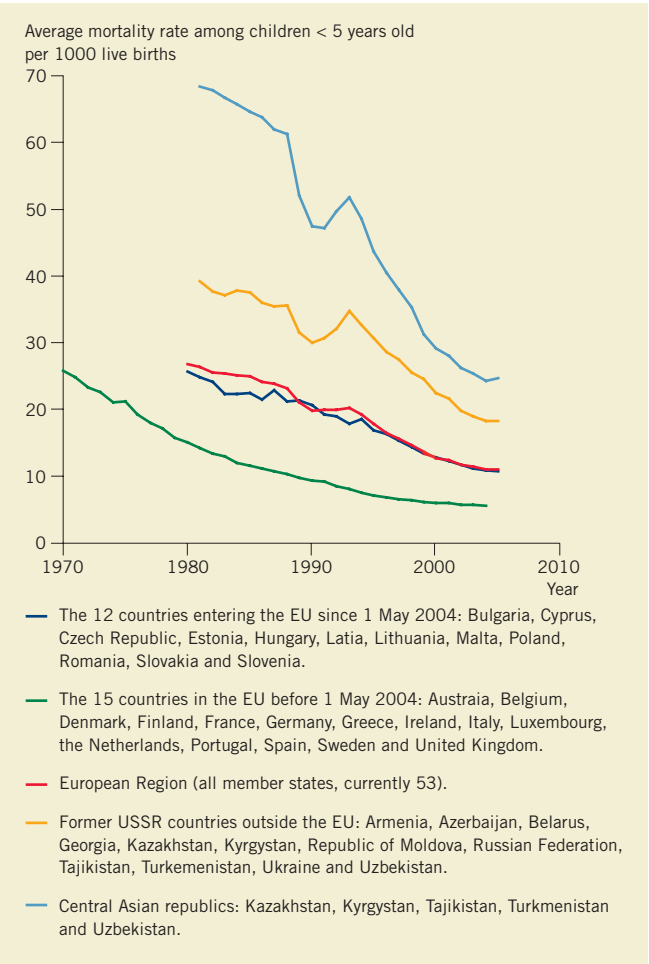

Figure 1. Mortality rate among children younger than five years per 1000 live births in various groups of countries in the WHO European Region, 1970-2005.

pean Region and within each country: children from different geographical, socioeconomic and ethnic groups experience very different living conditions. Thus, Tajikistan's mortality rate for children younger than five five years (the highest in Europe) is 40 times that of Iceland (the lowest in Europe). Conditions differ substantially within countries. A study [5] showed that more than 15% of the children in such countries as Ireland, Italy and the United Kingdom live in relative poverty (less than 50% of the median income) versus less than 5% in the Scandinavian countries. This is important given the clear associations between socioeconomic status and health.

Children and adolescents in the European Region have many and diverse health problems, and the situation is not consistent for the entire region, since each country has special circumstances and specific aspects that are key. Nevertheless, WHO's strategy specifically mentions three health aspects because of increasing trends in all parts of the region: HIV and AIDS; increasing overweight and obesity among children and adolescents; and psychosocial development and mental health.

The prevalence of HIV infection has increased for many years in the Russian Federation and Ukraine but also in the central Asian republics. The European Region has the highest increase in HIV prevalence of WHO's six regions although the absolute rates are still lower than in the high-prevalence countries. About 30-40% of the reported people living with HIV in the European Region are younger than 25 years, and the epidemic in the eastern part of the Region is largely promoted by injecting drug use. Mother-to-child transmission of HIV infection is similarly increasing as a result of a generally higher prevalence among mothers, although the absolute rate of transmission is still relatively low. Thus, mother-to-child transmission caused 3059 children to be infected with HIV in the European Region from 2000 to 2004 [6].

Many mental disorders that develop and are registered among adults begin in youth, and the prevalence of such mental disorders as depression and suicidal behaviour increases considerably during adolescence. An estimated 2 million young people in the European Region have a mental disorder, and many receive no or inadequate treatment. Depression is one of the most common mental disorders among young people and is associated with suicide, which is the third most frequent cause of death among young people in the European Region. Countries differ substantially, however, with the suicide rates among people 15 years and older ranging from two to 44 per 100,000 population [7].

Diet and nutrition and especially overweight comprise a third important determinant of health. Of the 77 million children in the EU countries, about 14 million are overweight (body mass index (BMI) = 25), and this number is increasing by about 400,000 million per year. Of the 14 million overweight children, about 3 million are obese (BMI = 30), and this number is increasing by about 85,000 annually. The prevalence of overweight among school-aged children in the European Region increased from about 8% in the 1970s to nearly 25% in 2003 [8, 9]. Again, the countries differ tremendously, with such countries in southern Europe as Italy, Malta, Portugal and Spain having a very high prevalence of overweight among school-aged children, whereas the Nordic countries, among others, still have relatively low rates. The causes of increasing overweight are complex, but changes in diet and physical activity are decisive factors.

A NEW WHO STRATEGY FOR EUROPE

The WHO European strategy for child and adolescent health and development was prepared in close collaboration with many partners. WHO held consultations with member states, international organizations and technical experts, and the strategy had been tested in numerous countries when the WHO Regional Committee for Europe approved it in September 2005.

The strategy is based on a broad concept of health and an understanding of health that views health in a life-course perspective. Such a starting-point requires focusing on the stages of life that are decisive for development and therefore require special efforts in promoting health, preventing disease and treating disease. These stages are pregnancy and birth; the first year of life; preschool age; from childhood to puberty; and adolescence.

The purpose of the strategy is to support member states in:

- creating a platform for assessing and critically examining national health and development programmes and action plans for children and adolescents, which will enable each country to reveal the improvements needed in health policy and legislation and to improve existing interventions
- promoting intersectoral cooperation in the efforts to focus on important health themes related to child and adolescent health and development,
- determining the role the health sector must fill in developing and coordinating legislation and policies for a health system that can meet the needs of children and adolescents.

OVERALL PRINCIPLES

The overall principles of the strategy are:

- health throughout life (a life-course approach) focusing on the health challenges associated with each stage of development from prenatal life to adolescence, such as infancy, early childhood and puberty,
- special efforts for disadvantaged people (equity): disadvantaged groups must be taken into account explicitly, including people with low income, socially marginalized people, ethnic minorities, people with mental disorders, people with disabilities and other people with special needs,
- intersectoral action: this means involving the entire health sector, including health promotion, disease prevention and disease treatment and close cooperation with other sectors such as social services, economics, education, environment and transport,
- participation of children and adolescents: the public, including children and adolescents, should be involved in planning, delivering and monitoring policies and services, which means that individuals feel joint responsibility for implementing various action plans.

These four principles are important aspects of achieving success in improving the health and development of children and adolescents. Further, having access to relevant information on the current health status of children and adolescents is important.

In accordance with the WHO's global guidelines [10], the strategy includes seven priority areas for action that should be incorporated in the overall planning of improving the health and development of children and adolescents: health for mothers and newborn babies; diet and nutrition; preventing and curing communicable diseases; preventing injuries and violence; action on the physical environment; comprehensively approaching the special health needs of children and adolescents; and psychosocial development and mental health. Thus, these are a combination of two essential stages in the life-course and five priority themes that influence health and development at all stages of the life-course.

Healthy mothers and newborn babies especially influence development during childhood, and the health and health behaviour of children and adolescents are an important prerequisite for a healthy adult life. The five priority health themes are important throughout life and reflect existing and future threats to health and well-being in all member states.

FROM THOUGHT TO ACTION

In theory, the strategy comprises a well-founded basis for action in each member state, but experience shows that converting words into

action is often difficult. WHO therefore prepared a toolkit to help to concretize and implement the strategy in each country.

The toolkit currently comprises three tools:

– an assessment tool: methods for assessing and reviewing existing policies, strategies and infrastructure related to child and adolescent health, including assessing whether they result in actual, successful intervention,
– an information tool: methods for identifying existing information for determining the heath status of children and adolescents, which is essential for developing effective measures to improve their health and also helps in developing indicators and identifying data for monitoring trends in health,
– an action tool: a catalogue of actions (such as legislation, regulations, policies and interventions) that have proven to be effective in improving the health of children and adolescents and to support them in their continuing development.

Further tools can be developed if necessary.

WHO gives high priority to the efforts to improve the health and development of children and adolescents in its future work. Future generations have to be well prepared for life in a world that is changing rapidly. WHO will attempt, in cooperation with relevant partners, to create an international agenda that supports positive development for children and adolescents in the European Region. WHO aims to work closely with each member state in its efforts to improve the health conditions for children and adolescents and aims to provide the necessary technical support for this work.

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