European Network of Ombudspersons for Children

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ENOC SYNTHESIS REPORT

Protection and Promotion of Children's Right to Physical Health

2025

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INTRODUCTION

The European Network of Ombudspersons for Children (ENOC) is a not-for-profit association of independent children's rights institutions (ICRIs). More specifically, ENOC links ICRIs offices established in the Council of Europe to promote children's fundamental rights. Its mandate is to facilitate the promotion and protection of the rights of children, as formulated in the UN Convention on the Rights of the Child.

ENOC wants to establish links and share information and strategies with independent children's rights institutions – children's ombudspersons, commissioners for children, or focal points on children's rights in national human rights institutions or general ombudsman offices.

By 2025, ENOC had grown to include 44 institutions in 34 countries within the Council of Europe, 22 of which EU countries. Membership is limited to institutions in the 46 member states of the Council of Europe.

ENOC has no profit-making intentions and its aims are:

- to promote and safeguard children's rights and to work on strategies for the fullest possible implementation of the UN Convention on the Rights of the Child;
- to serve as a forum of colleagues for the exchange of information, capacity building and professional support among the members;
- to promote the establishment of independent children's rights institutions (ICRIs) in countries worldwide and offer support to such initiatives, and to maintain an overview of other activities around the world and share more broadly beyond ENOC;
- to stimulate contacts and support with and among other ICRIs worldwide and their networks;
- to ensure, through advocacy and policy work, that relevant European-wide bodies place child rights at the centre of their activities, legislation and policies, and adopt a child rights approach to their work;
- to promote the active participation of children and young people in decision making processes, legislation, and policies concerning them. ENOC aims to implement such active engagement with and participation of children and young people in every aspect of ENOC's work and decision-making, including inter alia through consultations, engagement, and other activities;
- to initiate and coordinate strategic interventions on policy and litigation affecting children's rights agreed by at least two-thirds of full members of ENOC.

In order to achieve its general objectives, every year the members of ENOC choose, by majority vote, one current issue related to children's rights to advance their work in this area.

In 2025, ENOC specifically addressed the Protection and Promotion of Children's Right to Physical Health.

SURVEY

ENOC members were invited to participate in a survey (Annex 1), with the aim of exploring the present state of children's right to physical health across the ENOC membership, in order to support the elaboration of an ENOC policy position statement on the protection and promotion of children´s right to physical health.

The survey explored the level of availability, accessibility, acceptability and quality of the services and facilities of the healthcare systems, intended to ensure children's right to health across Europe, as well as the presence of the appropriate legislation, policies and practices for the prevention, treatment and care of health issues affecting children.

The survey has been designed by the ENOC Working Group to map out the key areas affecting children's right to health. It contains questions referring to existing national/regional policies and programs, the regulatory framework in force and good practices that are applied in ENOC jurisdictions in order to ensure all components that are part of the right to health, both education and prevention measures, as well as access to necessary treatments and care, including identification of the inequalities and discrimination on multiple grounds undermining children's health, and other factors identified by the members in line with individual country/region's patterns.

The survey consists of 4 parts, namely:

- Statistical data regarding children's health.
- Ensuring disease prevention measures and protection of children's health, including health literacy and health promotion on issues such as: nutrition, sports, hygiene, sexual and reproductive health, children's rest and other aspects which are key to a healthy lifestyle; mandatory vaccination schemes and development of the early intervention programs (for example, programs targeting child obesity, substance abuse, tobacco and alcohol consumption, sexually transmissible diseases, developmental disorders etc.); regulations ensuring road safety and safe environment for children.
- Children's access to necessary services, treatments and care according to their health needs, including access to medicines and provision of services for children with specific health needs (children with rare diseases, in palliative care, with disabilities etc.) and those in vulnerable situation.
- Place of the child in legislation on healthcare, including provisions that ensure respect for the child's rights to decide and to be informed, informed consent, respect for confidentiality and the right to complain and be protected.

27 ENOC member institutions provided answers to the survey. These are:

1. Malta - Office of the Commissioner for Children
2. Georgia - The Public Defender's (Ombudsman's) Office
3. Montenegro - The Protector of Human Rights and Freedoms (Ombudsman)
4. Italy – The National Authority for Children and Adolescents
5. Luxembourg – The Ombudsman for Children and Adolescents (OKAJU)
6. France – The Children's Defender, Office of the Rights Defender
7. Iceland - The Ombudsman for Children
8. Finland - Office of the Ombudsman for Children

9. Northern Ireland - Commissioner for Children and Young People (NICCY)
10. Basque Country/Spain - Ombudsman of the Basque Country/Spain (ARARTEKO)
11. Sweden – Office of the Ombudsman for Children
12. Flanders/Belgium – Office of the Children's Rights Commissioner
13. Andalusia/Spain - The Ombudsman's Office
14. Latvia – The Ombudsman's Office
15. Moldova - People's Advocate Office
16. Catalonia/Spain - Office of the Catalan Ombudsman
17. Poland – The Ombudsman for Children
18. Estonia – The Chancellor of Justice, Department for Children's and Youth Rights
19. Lithuania - Institution of the Ombudsperson for Children's Rights
20. Republika Srpska/Bosnia & Herzegovina – The Ombudsman for Children
21. Cyprus – The Commissioner for Children's Rights
22. Scotland - Children and Young People's Commissioner Scotland
23. Albania – The People's Advocate (Ombudsman's) Office
24. Ireland – The Ombudsman for Children's Office (OCO)
25. Croatia - The Ombudsman for Children
26. Norway – The Ombudsman for Children
27. Ukraine – Ukrainian Parliament Commissioner for Human Rights

I. HEALTH AT POLICY LEVEL

1.1. Children's Health in All Policies

Child's right to health

All children have the right to opportunities to survive, grow and develop with physical, emotional and social well-being, through access to the highest attainable standard of health, safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy. These rights are defined by the United Nations Universal Declaration of Human Rights (UDHR), which applies equally to individuals of all age groups, and the UN Convention on the Rights of a Child (UNCRC), which extends special care and protection to address the unique needs of children. A child's right to health is an inclusive right, which extends not only to health care services, but to a child's physical, mental, emotional and social well-being ensuring children are fed, vaccinated, educated, nurtured and protected from maltreatment.

Since children are still developing, they make up the most vulnerable population. UNCRC sets out the rights that must be provided for children to develop to their full potential, treating them as equal members of the community with responsibilities appropriate to his/her age and stage of development.

A child's right to health is defined in article 24 of UNCRC and refers to the appropriate and timely prevention, health promotion, curative, rehabilitative and palliative health care services. It also encompasses the right of a child to grow, play and develop to their full potential through the implementation of programs that address the underlying determinants of health. To fulfill the right to health for all children and reduce child morbidity and mortality, the implementation of locally developed evidence-based health policies and programs are needed. These should focus on providing age appropriate, low-cost prevention, treatment and protective measures that encompass the localized determinants of health and educate and empower local children, parents, caregivers and communities to develop and advocate for their right to health.

While UNCRC does not specify the exact range of services to which children should have access, it requires states to ensure the provision of necessary medical assistance and health care with an emphasis on the development of primary health care. The experts of the Committee on the Rights of the Child, who monitor the Convention's implementation and interpret the various different children's rights, see the right to health as an inclusive right in line with the WHO Constitution that should allow children to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health. Besides access to essential health care services, they also highlight the importance of children's mental health and the need to give special attention and protection to children at risk because of their family or social environments and to children affected by humanitarian emergencies[1].

A holistic approach to health is essential and places the right of children to health within the broader framework of international human rights obligations. Additionally, an increase in understanding of the social and structural determinants of health including poverty, unemployment, financial, economic, migration, population displacement, war, civil unrest, discrimination, marginalization and the impacts of climate change and urbanization show that more than ever a combination of biomedical, behavioral, social, cultural and structural intersections are needed to protect and fulfil a child's right to health.

[1] Palm W. et al. Implementation of the right to health care under the UN Convention on the Rights of the Child. Status report for the European Union, 2017. https://apps.who.int/iris/bitstream/handle/10665/332611/Eurohealth-23-4-3-6-eng.pdf?sequence=1&isAllowed=y

Applying a new approach - Children's Health in All Policies

Many of the factors that influence a person's health and well-being, such as their education level, income, housing and work conditions, are determined by social, environmental and economic policies beyond the direct control of the health sector. Thus, government policies and decisions made in all sectors and at all levels of government can have a significant impact on the health of the population, and in particular on equity in health. "Health in All Policies" is an approach that promotes collaboration between government sectors and non-government stakeholders to maximise the health benefits of government policies and reduce health inequalities, such as differences in life expectancy. It is also an approach that aims to minimise any harmful consequences of public policies on determinants of health and health systems. WHO defines *Health in All Policies* as referring to "taking health implications of decisions systemically into account in public policies across sectors, seeking synergies, and avoiding harmful health impacts, in order to improve population health and health equity through assessing consequences of public policies on determinants of health, well-being and on health systems" (WHO WHA 67.12 2014)[2].

This shared commitment makes it possible to work together in setting policy priorities and developing a *Children's Health in All Policies* (CHAP) approach. Improving children's health is not only based on increasing preventive and health care services, but also on improving healthy living conditions and ways of life. The health sector is essential to preventing and treating traumatic injuries and major childhood diseases. However, the incidence of risks for injuries and diseases can also be reduced by policy measures in other sectors. Policymakers have plentiful opportunities to improve children's health and safety at the local and state levels in multiple sectors, such as, for example, transportation (e.g., encouraging "active transport" by providing safe routes for walking and biking to schools) or education (e.g., mandatory active physical education). The goal of CHAP is to engage stakeholders, including legislators and representatives from government and non-government organisations, in exploring opportunities to create an integrated child health policy response across multiple sectors. CHAP is an enormously challenging strategy in which policies in social sectors such as transportation, housing, employment and agriculture ideally would contribute to [children's] health and health equity[3].

The health problems that children worldwide face today require intersectoral approaches, which can be achieved through comprehensive, multisectoral policies, with the involvement of all important actors in society. These issues can be grouped as[4]:

- *Lack of dedicated policy attention.* While children's needs are often considered in health and education policy, they are more rarely taken into account in other sectors – all of which need to work to make sure children have safe environments, healthy food, spaces to play, and the preparation they need to become healthy, active citizens.
- *Commercial exploitation of children through inappropriate marketing of products and services* such as alcohol, tobacco, sugar-sweetened beverages, breastmilk substitutes, and gambling apps is an underappreciated threat to their health and well-being.

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[2]World Health Organization. HEALTH IN ALL POLICIES. https://apps.who.int/iris/bitstream/handle/10665/151788/9789241507981_eng.pdf

[3] Children's Health in All Policies A Workbook. Kansas Health Institute 2010. https://www.khi.org/wp-content/uploads/2022/05/CHAPWeb.pdf

[4] Institute for Global health. CAP 2030 - Children in All Policies. https://www.ucl.ac.uk/global-health/research/z-research/cap-2030-children-all-policies

- *Climate change*, which is already negatively affecting children's health and well-being, constitutes a dire threat to their future. By amplifying the voices and perspectives of children, and by supporting policymakers with evidence and data about the impact on children, it is important to shift the emphasis to what works to protect them now and in the future.
- *Lack of voice.* Children have the right to voice their opinions and be heard on issues that affect them. It is important to develop tools to facilitate children's participation in policy issues.

Identifying solutions and solving these problems can only be achieved by unifying the forces of all sectors with joint efforts and resources. This should be the approach of contemporary society, where the interest of children, the protection of their health and well-being, should prevail over all other interests.

Survey results

Survey participants provided several examples of national documents assumed to be implemented through intersectoral collaboration.

> *"The National Nutrition Health Program (PNNS) adopts an intersectoral approach by involving various ministries such as health, agriculture, and national education, as well as local stakeholders, to promote healthy eating and regular physical activity. This collaboration aims to harmonise preventive actions and address social and regional health disparities. The PNNS is also aligned with broader strategies, including the National Health Strategy and the National Public Health Plan, thereby enhancing synergy among the involved sectors."*
>
> The Children's Defender, Institution of the Defender of Rights, France
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> *"Smoking and alcohol consumption are central issues of the National Cancer Plan 2020-2024 Luxembourg. This plan aims at reducing smoking among young people under 30 years of age and introducing prevention measures focusing on preventing alcoholism in adolescents. It was elaborated in collaboration with the Ministry of Health and other relevant organisations and administrations. The fight against nicotine addiction had already been addressed by the government in 2016 by the national tobacco plan (Plan National de Lutte contre le Tabagisme - 2016-2020). It was drafted by a 'tobacco working group' composed of representatives of 17 ministries, administrations and agencies."*
>
> The Ombudsman for Children and Adolescents, Luxembourg

In the survey conducted, we determined that in most of the ENOC member jurisdictions, the health of the child is appreciated as a priority, with separate policy documents being dedicated to promoting and protecting the interests of the child. 44.4% of respondents noticed the presence of a separate policy document dedicated to child health protection at the jurisdiction level. It is worth noting that the principle of "children's health in all policies" is applied in all the policy documents to almost a quarter of the participants. At the same time, every third respondent (33.4%) noted that child health is included only as part of the policy documents related to the general population health (Figure 1).

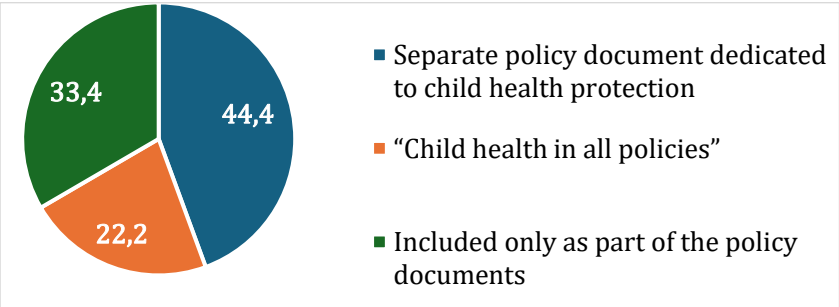

Figure 1. Ensuring the protection of children's health at the policy level in ENOC jurisdictions, %.

The initiatives that make children's health a national priority, with the broad involvement of all sectors, are commendable. Some respondents noted the presence of such documents in their jurisdictions.

> "*National Agenda for the Rights of the Child 2021-2026 is a document with strategic goals aimed at creating a safe and healthy environment for children, developing their maximum physical and psychosocial potential. The third goal of the Agenda focuses on child-friendly systems and services for children and adolescents and includes promoting child-friendly processes and systems, giving special focus to objectives related to health-related issues, with the aim of improving and increasing the quality of healthcare services to children*".
>
> People's Advocate, Albania

Policy level approach

A "Children's Health in All Policies" (CHAP) approach is a policy framework that recognises that children's health outcomes are influenced by a wide range of factors beyond the healthcare system, including education, housing, social protection, environment, and employment. This approach calls for cross-sectoral collaboration to improve the well-being of children by considering health impacts in all public policy decisions.

This approach is aligned with the UN Convention on the Rights of the Child (CRC), which calls for the promotion of children's well-being and their right to health. It requires integrating a health equity perspective into all areas of governance, from urban planning to environmental policies, ensuring that children's needs and rights are prioritised.

It is important to adopt a Whole-of-Government Approach by establishing a high-level coordinating body within government to oversee the implementation of policies, fostering inter-ministerial collaboration, and creating cross-sectoral working groups that include representatives from healthcare, education, housing, justice, social protection, and environmental sectors.

Children's health and well-being should be explicitly considered in policy impact assessments for all new policies or major legislation. This should include health impacts of economic and environmental policies, urban planning and transportation (e.g. creating child-friendly cities), education policies and early childhood care, family and social welfare policies.

Child health priorities have to be incorporated into national development plans, regional strategies, and local governance to promote equity and social justice.

Child-centred policies should be prioritised by involving children and adolescents in consultations and decision-making processes regarding policies that affect their lives. Accountability mechanisms that track progress on child health outcomes across all policy domains should be developed, using indicators such as child mortality rates, nutrition, access to education, and mental health services.

All public policies should address the root causes of health inequities that disproportionately affect children, such as poverty, inadequate housing, food insecurity, and poor access to education.

Policies that ensure access to healthy food, clean water, safe housing, and affordable healthcare for all children, especially those from marginalised communities, should be implemented.

The focus of the intersectoral approach should be the creation of safe, inclusive, and healthy environments for children, including public spaces, schools, and transportation systems that prioritise child safety, active mobility, and environmental sustainability.

1.2. Children's access to healthcare

Access to healthcare means having "the timely use of personal health services to achieve the best health outcomes." Access to comprehensive, quality healthcare services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all. Children's access to healthcare is a fundamental right and crucial for their well-being and future development. It involves timely access to appropriate services, including primary care, specialist consultations, and essential medicines. This access is vital for preventing and treating illnesses, promoting healthy development, and ensuring children can reach their full potential.

In most EU countries, all children have free access to outpatient care from general practitioners, services of infant nurses and vaccination programmes. The picture is similar for specialist care and dental care. On the other hand, the availability of free access to prescribed medicines depends considerably on the income situation of the child's household and on the country[5].

Survey results

26 out of 27 respondents mentioned that access to health services is universal for children under 18 years of age in their jurisdiction. Children who have recently migrated and undocumented children are not covered. If they have urgent medical needs, they are still covered. The exception (Flanders) is for children who have recently migrated and undocumented children. But if they have urgent medical needs, they are still covered.

Children's access to necessary healthcare depends greatly on the legal context through which these services are financed. Sources of funding and the extent of medical services provided to children differ across jurisdictions included in the study. In 20 jurisdictions (74.1%) the public budget covers in full volume all expenses for healthcare provided to children. The public budget partially covers the necessary expenses for children's treatment in 5 jurisdictions (18.5%). In the Republic of Srpska, children's insurance depends on the insurance of the parents, but the Law on Health Insurance regulates the other possibilities of children access to healthcare with costs paid from public budget if the parents have not been insured.

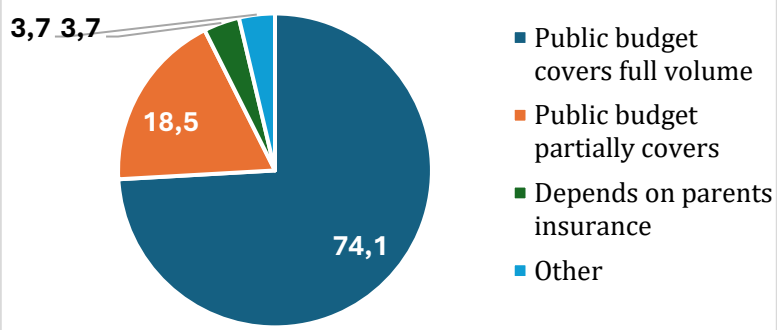

Figure 2. Covering the costs of health services provided to children, 27 jurisdictions, %.

[5] Access for children in need to European Child Guarantee key services. Report. https://employment-social-affairs.ec.europa.eu/news/new-report-published-access-children-need-european-child-guarantee-key-services-2023-09-20_en#:~:text=Healthcare:%20In%20most%20EU%20countries%2C%20all%20children,similar%20for%20specialist%20care%20and%20dental%20care.

There are also some particular models of financing health services for children, such as that of Belgium.

> *"In Belgium, health insurance is largely managed by mutual health insurance funds, known as "mutualities" (mutualiteiten/mutualités). These are non-profit organisations that provide access to compulsory health insurance and additional health-related benefits. Membership fees are free of charge or very low (3 euros a month, for example). The "mutuality" usually pays most of the fee (both for children and adults). For example, when you visit a general practitioner, there is a co-payment of 4 euros, the mutuality pays the rest."*
>
> Office of the Children's Rights Commissioner, Belgium/ Flanders

The majority (25 out of 27 respondents) - 92.6%, mentioned that in their jurisdictions, prevention and prophylaxis services, including vaccination and periodic health checks, are provided free of charge for children. In many jurisdictions (81.5%), children are provided with free hospital care for all illnesses, outpatient treatment at the family doctor and the paediatrician. In more than a third of the jurisdictions (37%) included in the survey, children are provided with full dental services, including prosthetics.

However, it is worrying that in some jurisdictions, children are provided with free medical services only for emergencies and life-threatening situations.

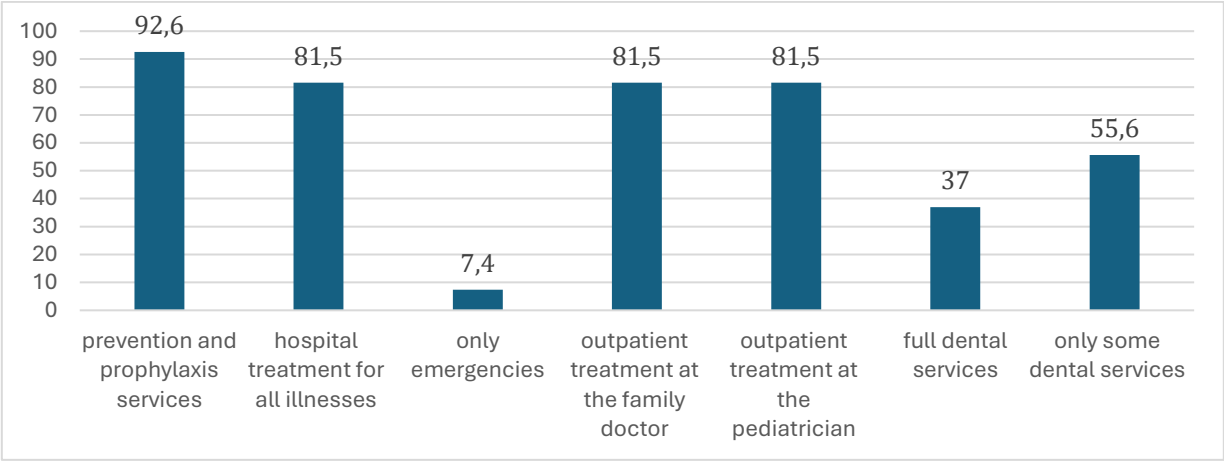

Figure 3. Free of charge healthcare services provided to children, 27 jurisdictions, %

> *"Except vaccination, no medical service is free of charge. The parents always pay a small contribution. Outpatient services are mostly covered by the mutuality, hospital treatment only partly – private insurance is recommended for hospital treatment. Basic dental care is reimbursed for minors through mutual insurance if the dentist is conventional. Most dentists work through a third-party payer system, which means that they arrange this with the mutual insurance company, and therefore the parent does not have to advance anything for basic dental care*."
>
> Office of the Children's Rights Commissioner, Belgium/ Flanders

A very important aspect in ensuring access to healthcare services is providing children with free essential medicines (those that satisfy the priority healthcare needs of the pediatric population). It is worrying that in about 22% of the jurisdictions included in the survey, the pediatric formulations are accessible and affordable partially. In more than half of the jurisdictions (51.9%), expenses for children's medications are partially covered by public funds.

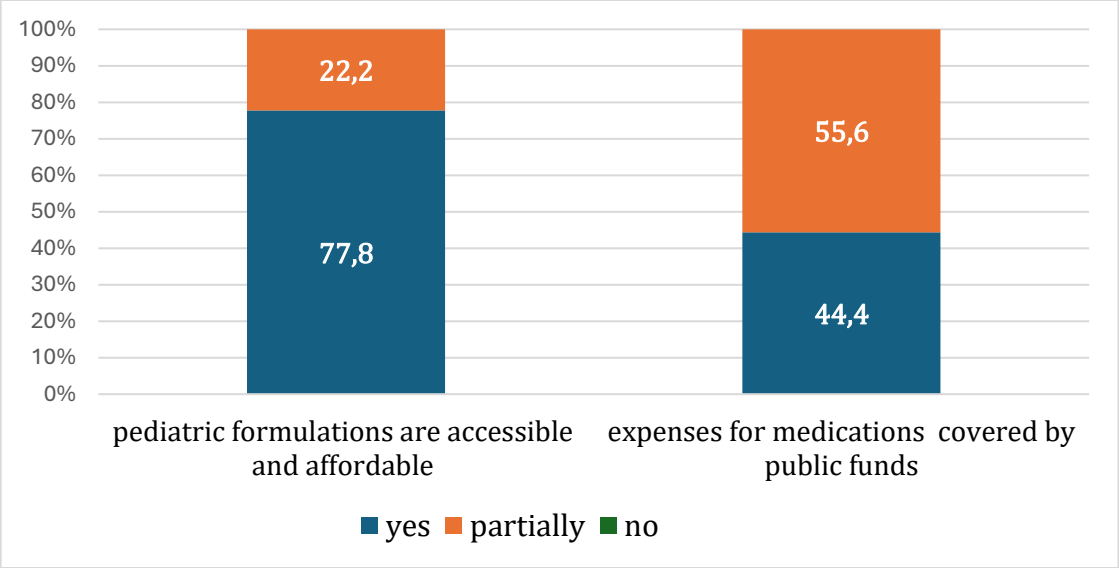

Figure 4. Access to pediatric formulation and essential medicines, 27 jurisdictions, %

"*Essential pediatric medicines are widely available and partially or fully reimbursed through the Caisse Nationale de Santé (CNS). Many essential medications are covered at 100% for children under 18 when prescribed by a doctor. Most essential medications are covered depending on the type of drug, but non-essential or over-the-counter drugs are not covered. Hearing aids for children are covered but within specific price limits. Basic corrective lenses are covered, but frames and premium lenses may require co-payment. Wheelchairs and orthopedic equipment are partially reimbursed. Special allowance can be offered for children with a higher level of disability.*"

Ombudsman for Children and Adolescents, Luxembourg

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"Since January 1, 2021, the "100% Santé" program offers all French citizens, who benefit from responsible supplementary health insurance or the Complementary Health Insurance Solidarity (CSS), full coverage for a wide range of services and equipment in audiology, optics, and dentistry. Regarding the coverage of wheelchairs – Decree of February 6, 2025, modifying the terms of coverage for medical devices and associated services for the provision of vehicles for people with disabilities (VPH) under Sections I and IV of the list outlined in Article L. 165-1 (LPP) of the Social Security Code – 100% coverage will apply starting December 1, 2025."

The Children's Defender, Institution of the Defender of Rights, France

Paediatric care should be organised and provided by recognising that children`s health, physical, psychosocial, developmental, communication and cultural needs differ from those of adults[6]. For this reason, the presence of pediatric specialists or the assumption of pediatric specificities within different medical specialities is of major importance.

[6] WHO. Standards for improving the quality of care for children and young adolescents in health facilities. https://apps.who.int/iris/bitstream/handle/10665/272346/9789241565554-eng.pdf

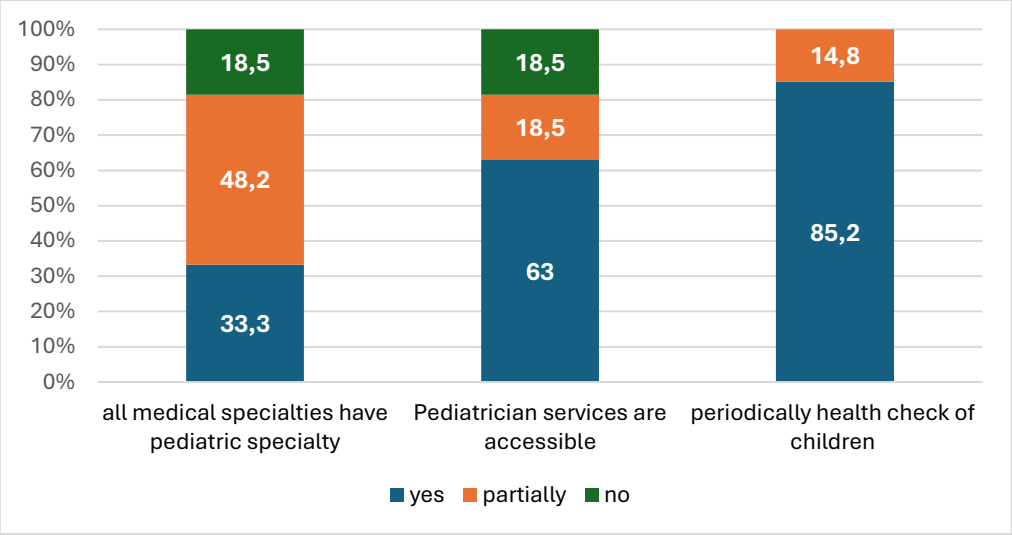

Figure 5. Health services adjusted to the age of children, 27 jurisdictions, %

"In Georgia, pediatric services are integrated into the primary healthcare system, and periodic checkups for children (especially under 5 years of age) are clearly outlined in national protocols, including growth and developmental assessments, immunisations, and screenings. These services are provided free of charge. Paediatricians are not equally accessible across the country due to shortages, particularly in villages. However, paediatricians are still available in nearby towns or cities. Considering socio-economic factors, this can still pose some barrier for some families, especially those who are socially or economically vulnerable, as travel may involve additional costs and logistical challenges."

The Office of the Public Defender, Georgia

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"Almost all medical specialties in Lithuania have a separate pediatric specialty, though some specialties apply to both children and adults without a clear separate pediatric specialization (e.g. medical specialties with pediatric branches in Lithuania are: pediatrics, pediatric surgery, pediatric cardiology, pediatric neurology, pediatric endocrinology, pediatric nephrology, pediatric pulmonology, pediatric gastroenterology, pediatric orthopedics-traumatology, pediatric oncology, pediatric hematology, pediatric rheumatology, pediatric dermatology, pediatric psychiatry, pediatric ophthalmology, pediatric dentistry). In Lithuania, paediatrician services are generally accessible to all children; however, certain regional disparities can affect access in practice - major cities have better access to paediatricians and specialists, while rural areas may have a shortage of paediatricians, leading to longer waiting times or the need to travel for services. The frequency of health monitoring of children depends on their age: newborn (from birth to 28 days of age) - once every 3 working days in the hospital and additionally 1 - 2 times a month; infant (from birth to 1 year of age) - once a month; from 1 year to 18 years - once a year."

The Ombudsperson for Children's Rights, Lithuania

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"There are pediatric specialties in all medical departments of major hospital centers, but not in all hospitals. This lack of medical coverage in certain areas highlights the issue of medical deserts, where not all children have equal access to healthcare. In 2021, eight departments had fewer than one pediatrician per 100,000 inhabitants, exacerbating healthcare inequalities. However, all children systematically benefit from 20 health check-ups, which take place until the age of 16. These check-ups are fully covered by Health Insurance, based on official rates (excluding extra fees) and with no upfront

costs. For the three check-ups that result in a certificate (COE), the consultation must be conducted at the regulated fee."

The Children's Defender, Institution of the Defender of Rights, France

Policy level approach

All children, regardless of their socio-economic background, geography, or any other barriers, must receive the care they need to grow, develop, and thrive. This approach must be comprehensive, inclusive, and equitable, ensuring that children have timely access to essential health services, from preventative care to specialised treatments. The approach should be aligned with international frameworks, such as the UN Convention on the Rights of the Child (CRC), which guarantees children's right to health, and WHO health systems principles, which emphasise universal access and equity.

Universal Health Coverage should be a national priority, ensuring that all children have access to the full spectrum of health services, including:

- Preventive care (vaccinations, health screenings, nutrition programs)
- Primary health services (general pediatric care, mental health services)
- Specialised care (for chronic conditions, disabilities, mental health)

The financial barriers (e.g., high out-of-pocket costs, insurance gaps) must be eliminated for children's healthcare.

The primary healthcare centres should be well-distributed across both urban and rural areas and are child-friendly, with the necessary facilities for diagnosis, treatment, and prevention of common childhood illnesses.

Access to essential medicines and vaccines should be guaranteed. All children should have free access to affordable medicines, including routine vaccines and emergency immunisation responses to outbreaks, antibiotics, and treatment for chronic conditions (e.g., asthma, diabetes, epilepsy, pain killers).

Children in vulnerable situations should be offered financial support, such as those living in low-income households, refugee children, migrant children, and those with disabilities.

Mental health services should be integrated into general healthcare settings and schools**,** with a focus on preventive care**,** early intervention, and access to specialist care when needed. It is important to promote school-based mental health programs, community outreach, and mental health training for educators, caregivers, and health professionals.

It is recommended to develop national child health registries and data systems to monitor health outcomes, such as vaccination rates**,** nutrition**,** childhood diseases**,** and mental health indicators**.** Child health data should be disaggregated by age, gender, and socio-economic status to identify gaps in service provision and address health inequities**.** This data could be used for evidence-based decision-making and policy improvement, ensuring that policies adapt to emerging child health needs (e.g., obesity**,** mental health challenges, chronic diseases).

1.3. Right to health without discrimination

Public health problem

States have to ensure the protection of children's right to health regardless of their nationality, ethnicity, background and gender, without any discrimination, and actively advocate to stakeholders to

provide children with the opportunities to survive, grow and develop with the highest level of physical, mental, emotional and social well-being. It is important to develop and extend special care and protection to address the unique needs of children, prevent maltreatment, and provide the highest quality, accessibility and availability to healthcare.

A status report that was produced at the request of the European Commission assessed the minimal compliance of EU Member States with the legal obligation contained in Article 24 UNCRC to ensure access to health care services for all children (own nationals, children with EU/EEA citizenship or any other nationality, children with asylum-seeking status and children with irregular residence status). Only four countries (Croatia, Cyprus, Italy and Spain) have actually enshrined in their legislation a specific legal disposition that establishes an unconditional and universal right to health care for all children living in their territory, irrespective of their legal status. Both Cyprus and Italy actually explicitly refer to the UNCRC. In seven other countries (France, Greece, Malta, Poland, Portugal, Romania and Sweden) access to health care is ensured to all four mentioned groups of children through regular legislation by setting out the eligibility criteria or by organizing special additional schemes for specific groups that fall outside of the main statutory coverage. In the remaining 17 Member States certain categories of children may not be covered or not sufficiently covered by law[7] (Figure 6).

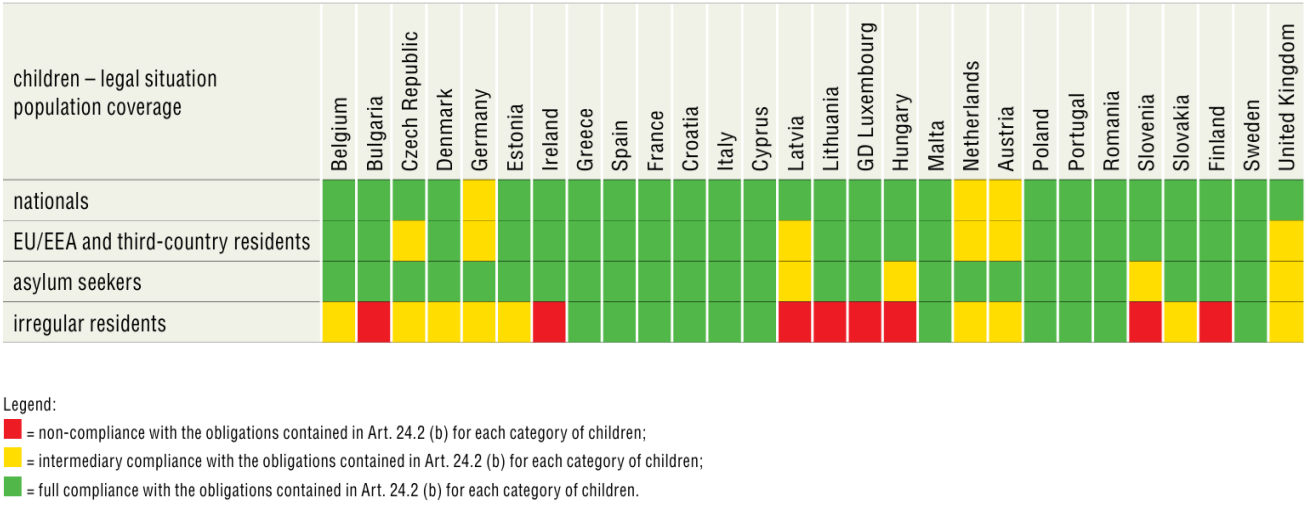


Figure 6. Basic assessment of EU Member States' legal compliance[8]

Whereas access only to emergency care is clearly too restrictive, several countries use the concept of "urgent medical aid" to describe the range of services covered for children that are not covered by the regular system. While this is broader than just emergency care and would typically include regular primary care, pre- and post-natal services to new-born babies and their mothers, as well as preventive care (including vaccinations), it would exclude elective forms of care.

[7] Palm W. et al. Implementation of the right to health care under the UN Convention on the Rights of the Child. Status report for the European Union, 2017. https://apps.who.int/iris/bitstream/handle/10665/332611/Eurohealth-23-4-3-6-eng.pdf?sequence=1&isAllowed=y

[8] Palm W. et al. Implementation of the right to health care under the UN Convention on the Rights of the Child. Status report for the European Union, 2017. https://apps.who.int/iris/bitstream/handle/10665/332611/Eurohealth-23-4-3-6-eng.pdf?sequence=1&isAllowed=y

In general, depending on the type of health system, children are normally covered either directly on the basis of citizenship or residence status, or indirectly as dependents of their statutorily insured parents or legal guardians. Children are often granted a special status when it comes to entitlements to health care, as is also the case with pregnant women and mothers. This not only relates to general eligibility to statutory health coverage but can also generate more comprehensive coverage compared to adults.

Some countries apply child-specific user charge policies (reductions, caps, or exemptions) to ensure affordable care for children. Also, special attention is given to ensure children's access to preventive services. The special status generally applies until the legal age of 18 but is extended for as long as children are enrolled in education and remain financially dependent on their parents or guardians. For disabled children, this status is sometimes continued indefinitely, or they are covered in their own right.

Especially in countries with statutory health insurance systems that are based on the professional status of the parent or on the payment of contributions or insurance premiums, certain children may fall between the cracks and be left without coverage, especially if parents or guardians are not in compliance with administrative or financial conditions for statutory health insurance. Also drawing on the hybrid social insurance models that were developed in some of the Central European Member States after political transition, where children are insured in their own right as non-contributing persons or based on state contributions, several Western-European countries have also introduced mechanisms to stabilize entitlements and ensure continuity of coverage.

In countries where statutory coverage is based on residence status, the definition of permanent residence can vary considerably. Some apply a looser notion while others are very strict in requiring permanent legal residence for obtaining statutory health coverage. Actually, in order to obtain residence status, countries will often require immigrants to provide evidence that they have, for themselves and their family members, sufficient resources and comprehensive sickness coverage in the host Member State. This is not only the case for third country nationals (non-EU/EEA citizens) but also for economically non-active EU/EEA citizens who reside in another Member State for longer than three months (Directive 2004/38/EC). Generally, seamless transition can be guaranteed through the Regulation 883/2004 on the coordination of social security systems but for children who were previously not covered by any social security system in an EU Member State (e.g. EU citizens with irregular residence status, privately insured, children of international civil servants, non-EU/EEA residents who were previously insured outside the EU/EEA), eligibility to health care coverage may not be guaranteed. These are groups that often remain unnoticed in-migrant policy documents and regulations.

Survey results

The most vulnerable group are indeed migrant children who arrive in a country with an unclear or irregular residence status. The status of being a migrant is often more important than being a child when it comes to defining entitlements and eligibility. Their access rights are often conditional and restricted to a limited set of services (emergency care or 'urgent medical aid').

> "*Children who have recently migrated and undocumented children are not covered. If they have urgent medical needs, they are still covered.*"
>
> Office of the Children's Rights Commissioner, Belgium/Flanders

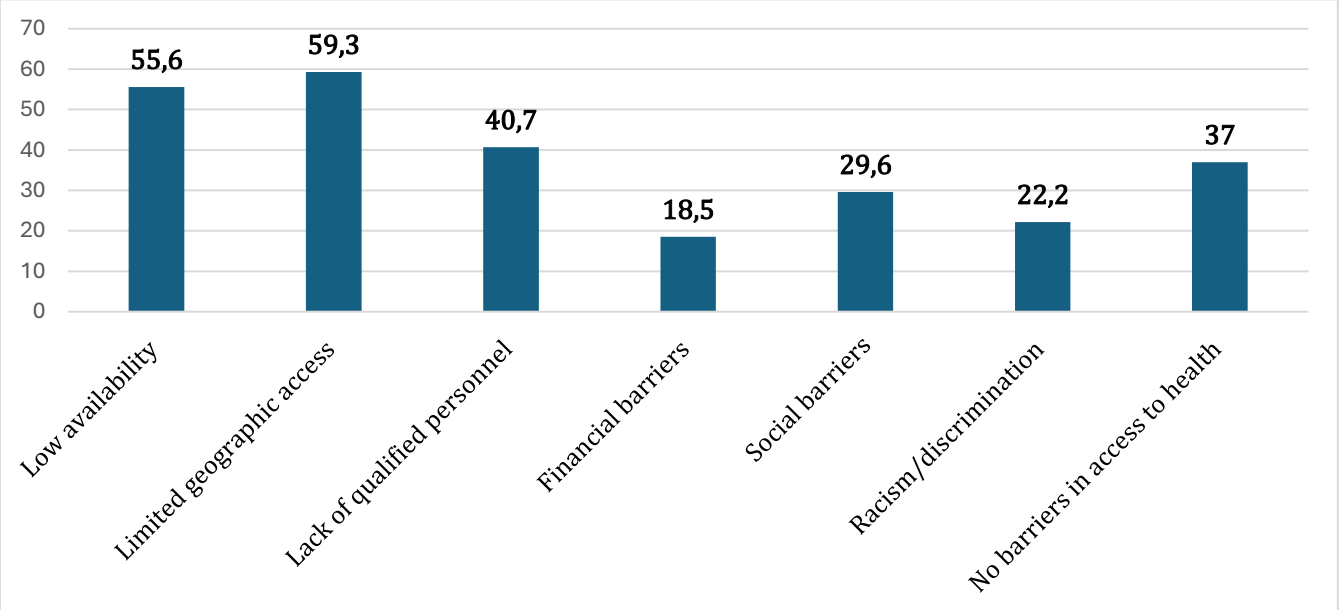
Administrative requirements, lack of information and financial barriers (e.g. compulsory registration with a general practitioner, having a place of residence, prior assessment of the financial state of indigence, up-front payment) can further impede access to care and sometimes make eligibility rather

theoretical. In some countries, children with irregular residence status are better protected than adults. For example, in France they are immediately covered on arrival under a specific state insurance scheme (called AME – 'Aide Médicale d'État') whereas adults are only covered after three months. Georgia has general policies aimed at ensuring universal access to healthcare, such as the Universal Health Care Program, which covers children. Among children, unaccompanied minor foreigners sometimes get broader entitlements, with direct statutory coverage in several Member States. While this can be justified by the specific needs that are generated by their precarious condition it also generates questions around discrimination by family status[9].

When children apply for international protection and are registered as asylum seekers, they are formally granted protection, including access to health services.

> *"In Cyprus, special provisions have been introduced to ensure that children as well as pregnant women who belong to vulnerable groups and are not eligible for registration to the national healthcare system (e.g. atypical immigrants, rroma, etc.) have access to free healthcare. All children have free access to the emergency department of all public hospitals and to the Maternal and Child Welfare Centers."*
>
> The Commissioner for Children's Rights, Cyprus

However, we note that barriers to access to healthcare services are determined not only for people who have residency or citizenship issues. In the survey, respondents mentioned a number of barriers that, in their opinion, limit the right of children and adolescents to healthcare (Figure 7). Well over half of the respondents mentioned problems with the availability of pediatric care (55.6%), as well as the remoteness and geographical location of localities (59.3%), which sometimes represent a serious barrier to access to necessary health services.



[9] Palm W. et al. Implementation of the right to health care under the UN Convention on the Rights of the Child. Status report for the European Union, 2017. https://apps.who.int/iris/bitstream/handle/10665/332611/Eurohealth-23-4-3-6-eng.pdf?sequence=1&isAllowed=y

Figure 7. Barriers encountered in accessing health services for children, 27 jurisdictions, %

"In some areas of Italy, especially rural or less developed areas, access to health facilities may be limited due to an uneven distribution of services, with some areas not having easily accessible hospitals or clinics. Families in socially or economically disadvantaged situations may face obstacles in accessing services, due to difficulties in navigating the system or accessing prevention and treatment services, because of low information or other socio-economic difficulties. In some situations, children from migrant families or vulnerable social groups might face difficulties in accessing health services, even if the system is universal."

The Authority for Children and Adolescents, Italy

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"In certain areas our country lacks availability of the necessary number of specialised and trained healthcare professionals to manage all needs for pediatric patients, i.e. lack of adequate number of pediatric nephrologists, pediatric gastroenterologists, etc."

The Commissioner for Children's Rights, Cyprus

To avoid situations with a risk of violating the right to health and discrimination, additional specific policies are developed in most jurisdictions to ensure equitable access to healthcare services for all children, regardless of their socio-economic background, ethnicity, or disability.

"The Health Care Act (2017:30) emphasises that health care should be provided on equal terms for all, and children's needs must be given special consideration. The Discrimination Act (2008:567) prohibits discrimination in healthcare. For children in vulnerable socio-economic groups, guidelines are in place to ensure that they receive free healthcare. Children with disabilities have the right to special care and treatment. Child health centers and school health services are available to all children in Sweden."

Office of the Ombudsman for Children, Sweden

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"In Italy, there are policies and regulations that guarantee equal access to health services for all minors, regardless of their socio-economic background, ethnicity or disability. These policies are mainly based on the principle of universality and equality enshrined in the Italian Constitution and the National Health Service"

The National Authority for Children and Adolescents, Italy

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"*Georgia has general policies aimed at ensuring universal access to healthcare, such as the Universal Health Care Program, which covers children. At the same time, there are also targeted programs for socially vulnerable children and those with disabilities*".

The Office of the Public Defender, Georgia

When asked to provide an assessment of the level of assistance provided to children in vulnerable situations (e.g. refugees, minorities, children with disabilities), respondents critically assessed the situation in their own jurisdictions, leaving room for improvement, offering a "fair" or even "poor" assessment (Figure 8).

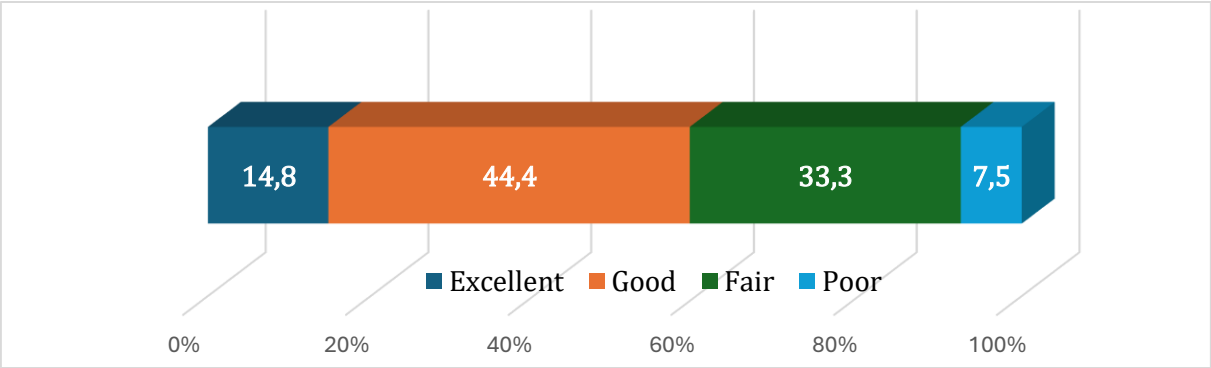

Figure 8. The healthcare services provided to children from vulnerable groups, 27 jurisdictions, %

> "*There are several Competence centres for school-aged children with disabilities. Access to specialised care, rehabilitation, and assistive technologies for children with disabilities is available but may involve waiting times. Parents sometimes have difficulties navigating the administrative processes for obtaining financial support. Refugee children receive medical screenings upon arrival, often coordinated by the National Reception Office. s: Interpretation services are available but not always systematically provided (language barriers). Mental health services: Psychological support is available but may be limited. Health outcomes for children from socio-economically disadvantaged backgrounds can be lower due to a lack of awareness or administrative obstacles in accessing healthcare services.*"
>
> The Ombudsman for Children and Adolescents, Luxembourg

Policy level approach

The right to health without discrimination for children is a fundamental principle enshrined in international human rights law, including the UN Convention on the Rights of the Child (UNCRC) and the European Convention on Human Rights. Article 24 of the UNCRC specifically guarantees children the right to enjoy the highest attainable standard of health and access to health care services. The principle of equity in healthcare access is further emphasised, meaning that children should have equal opportunities to access healthcare regardless of their circumstances. Guaranteeing non-discriminatory access to healthcare is a principal duty of every State.

The Council of Europe *Guidelines on child-friendly healthcare*[10] propose an integrated approach that places children's rights, needs and resources at the centre of healthcare services, taking into account their family and social environment. The five principles – participation, promotion, protection, prevention and provision – are particularly relevant to the child-friendly healthcare approach.

No child should be excluded from healthcare assistance based on socio-economic status, disability, or geographic location (urban vs rural). Discrimination in healthcare settings should be forbidden by ensuring that all children, regardless of their background, are treated equally and respectfully.

It is necessary to implement targeted policies to address health disparities faced by children from marginalized or disadvantaged backgrounds, such as migrant children, refugees, children with disabilities, and ethnic minorities.

The specific health needs of rural and remote populations, where access to healthcare can be more limited should be addressed. This could include mobile health services, telemedicine and digital health solutions, training and support for community health workers in rural settings.

[10] https://www.coe.int/en/web/compasito/child-friendly-healthcare

II. HEALTH PROMOTION AND DESEASES PREVENTION

The right to health is closely linked to other fundamental human rights. The health, water and sanitation, education and social protection systems must all work together to provide children and their families with the knowledge, support and services they need to ensure better growth and development. Prevention and awareness campaigns are essential in realizing the right to health and promoting public health, especially children's health. Spreading basic information about hygiene and nutritional needs for instance can improve healthy behavior by informing the population of fundamental rules when it comes to protecting their health. Awareness campaigns should be also used to address threats to health faced by children, such as child marriage and female genital mutilation that both have harmful impacts.

2.1. Children's nutrition

Public health problem

Children need the right food at the right time to grow and develop to their full potential. Meeting children's nutrient needs in early life can be challenging, and many parents face barriers to securing enough nutritious, safe, affordable and age-appropriate food for their children. Children's diets are frequently comprised of grains – with little fruit, vegetables, eggs, dairy, fish or meat. Many are increasingly being fed sugary drinks and packaged snacks high in salt, sugar and fat. Poor diets in childhood can lead to deficiencies in essential vitamins and nutrients – such as vitamin A deficiency, which weakens children's immunity, increases their risk of blindness and can lead to death from common childhood diseases like diarrhoea. These challenges are even greater during conflicts, disasters and other humanitarian crises[11].

2.1.1. Breastfeeding

In the first two years of life, breastfeeding saves lives, shields children from disease, boosts brain development and guarantees children a safe and nutritious food source. UNICEF and the World Health Organisation (WHO) recommend that infants begin breastfeeding within one hour of birth, be exclusively breastfed for the first six months, and continue breastfeeding until 2 years of age or beyond. Yet, today, many infants and young children are not receiving the nutrition they need to survive and thrive. Fewer than half of the world's newborns are benefiting from the life-saving power of breastfeeding during the first hour of life. And only three out of five infants younger than 6 months of age are breastfed exclusively. Children's first foods too often lack diversity and are low in energy and nutrients. Globally, one in three children aged 6–23 months is eating the minimum diverse diet needed for healthy growth and development.

Exclusive breastfeeding (the practice of only giving an infant breast milk for the first 6 months of life) is a cornerstone of child survival and child health because it provides essential, irreplaceable nutrition for a child's growth and development. It serves as a child's first immunization – providing protection from respiratory infections, diarrhoeal disease, and other potentially life-threatening ailments. Exclusive breastfeeding also has a protective effect against obesity and certain noncommunicable diseases later in life. Globally, only 38% of infants aged 0 to 6 months are exclusively breastfed. Recent analyses

[11] UNICEF. Early childhood nutrition. Preventing malnutrition in infants and young children. Available at https://www.unicef.org/nutrition/early-childhood-nutrition

indicate that suboptimal breastfeeding practices, including non-exclusive breastfeeding, contribute to 11.6% of mortality in children under 5 years of age.

Survey results

Based on the survey conducted, we can conclude that breastfeeding practices are implemented differently across jurisdictions within ENOC. 16 out 27 respondents (59.3%) have a comprehensive national policy / program on infant and young child feeding, 7 jurisdictions (25.9%) have only partially implemented such a program, and four responding jurisdictions (14.8%) have noted the lack of such programs. Only in 9 jurisdictions out of the total of 27 respondents there is a national coordinator and a multisectoral national breastfeeding committee. In many jurisdictions participating in the study (77.8%) there are mandatory education sessions for pregnant women and in postnatal care. Not all jurisdictions pay sufficient attention to information campaigns (table 1).

Table 1. The breastfeeding practices promoted in 27 jurisdictions

	Yes	No	Partially
There is a comprehensive national policy / program on infant and young child feeding	16	4	7
There is a national coordinator and a multisectoral national breastfeeding committee	9	14	4
Mandatory BF education sessions for pregnant women and in postnatal care	21	3	3
Mass or social media campaign	14	5	8
Limitation of promotion and marketing of food products that compete with breastfeeding (with monitoring mechanisms and deterrent sanctions for violators) – implementation of the provisions of the International Code of Marketing of Breast-milk Substitutes	13	9	5
Legal framework for promotion of community and workplace support to mothers in relation to pregnancy and lactation (such as breastfeeding facilities in the workplace, breastfeeding breaks etc.)	15	5	7
Support programs for good nutrition for pregnant and lactating women	14	3	10

Respondents shared some challenges and problems in implementing WHO recommendations on promoting breastfeeding.

"The national policy is a strong policy that has never been implemented. BF education provided by Mater Dei Hospital (MDH) is only through online lectures, there are no longer face to face classes which create much more interaction. There have been advertising campaigns spasmodically but not on social media. Marketing of breastmilk substitutes and articles covered by the International Code of Marketing has become rife on social media. As well as influencers there are now a number of private organizations offering childbirth education and support that are frequently sponsored by the baby food industry with mass social media marketing attached to the event. At MDH and government level the code is quite well adhered to, however nationally there is no set protocol for monitoring and implementing sanctions to violators. Legally workers in the public sector are intitled to 2 30 min breastfeeding breaks when returning to work until baby is 9 months of age. I believe this does not apply to private sector they are given breaks on the goodwill of their employer. Although MDH runs an Infant

Feeding Clinic to support ongoing breastfeeding general medical management of infant feeding has recently swung to favour formula feeding. The fear of underfed babies has led many health professionals to adopt practices that encourage overfeeding."

Office of the Commissioner for Children, Malta

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"Georgia promotes breastfeeding primarily through maternal and child health services under the Universal Health Care Program, where antenatal and postnatal care include breastfeeding counseling. Maternity hospitals provide guidance on breastfeeding as part of early postnatal care. However, there is no comprehensive national policy or multisectoral coordination mechanism specifically dedicated to infant and young child feeding. BF education sessions for pregnant women and in postnatal are financed by individuals themselves. There have been limited mass media initiatives related to breastfeeding, that are not continuous or institutionalized. The International Code of Marketing of Breast-milk Substitutes has not been fully implemented or enforced through national legislation. Furthermore, it is noteworthy, that Georgia's Labor Code includes provisions on maternity leave and limited breastfeeding breaks, but broader community and workplace support mechanisms (e.g., breastfeeding rooms, legal obligations for lactation support) are not mandated or widespread. Support for maternal nutrition is addressed within broader reproductive health or social assistance programs, but not as a structured national effort."

Office of the Public Defender, Georgia

At the same time, the survey also collected a lot of good practices that deserve to be shared and taken over by other jurisdictions. Many respondents described positive approaches to implementing breastfeeding policies in their jurisdictions.

"In Iceland, breastfeeding is actively promoted through a combination of national policies, healthcare practices, and public health initiatives. The high breastfeeding rates in Iceland indicate that the idea that all women should breastfeed is culturally very strong. Adherence to WHO Recommendations: Iceland aligns with the World Health Organization's guidelines, advocating for exclusive breastfeeding during the first six months of an infant's life, followed by continued breastfeeding alongside appropriate complementary foods up to two years of age or beyond. Healthcare facilities offer support services, including counseling and peer support groups, to assist mothers with breastfeeding challenges. These services are designed to provide practical assistance and emotional support, encouraging sustained breastfeeding practices."

The Ombudsman for Children, Iceland

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"On this framework, the Ministry of Health and the organization authorized in Spain to promote the implementation of WHO and UNICEF's "Baby Friendly Hospital Initiative", that is the Initiative for the Humanization of birth assistance and breastfeeding, signed a specific agreement to promote, protect and support breastfeeding last September, 2024. At the regional level, the Strategy for the promotion of a healthy lifestyle specifies several measures related to children and adolescents, including the promotion of breastfeeding at the different levels of the public health services (both at primary and hospital care) and as part of the preparation programs for childbirth. It also highlights the importance of developing the network of maternal milk banks (3 in Andalusia) to attend the needs at hospitals. Other interesting and specific actions can be found in the "bank of good practices" related to breastfeeding included in the Child and Adolescent Health Strategy. "

The Ombudsman's Office, Andalusia/Spain

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"To promote breastfeeding, annual awareness campaigns are organised from August 1 to 7 as part of World Breastfeeding Week. These campaigns target the general population, pregnant women, and

mothers with newborns, ensuring national coverage and extensive media promotion through mass media, social networks, medical institutions, and other channels."
"There are several programs and initiatives to support healthy nutrition for pregnant and breastfeeding women, namely: Breastfeeding Caravan: organized annually by the Ministry of Health in collaboration with WHO Office, offering informational sessions; Baby-Friendly Hospital Initiative (BFHI), supported by UNICEF since 2000, with aim to transform all maternity hospitals into breastfeeding-friendly centers. To date, over two-thirds of maternity hospitals have achieved "baby-friendly" status, compared to just 13% in 2000; training Programs for medical staff: UNICEF has supported the training of approximately 180 primary healthcare specialists, equipping them with skills in outpatient care, nutrition, breastfeeding support, and HIV testing services for pregnant women."

People's Advocate for child's rights, Republic of Moldova

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"In Norway, breastfeeding is actively promoted through a comprehensive and publicly funded maternal and child health service. Families receive close and continuous follow-up through the Child and Family Health Centers (CFHCs), which are universally accessible and free of charge. These centers offer individualized breastfeeding guidance provided by public health nurses, who have specialized education in health promotion and preventive care. Their expertise ensures high-quality support tailored to each family's needs, starting during pregnancy and continuing through the postnatal period."

The Ombudsman for Children, Norway

Policy level approach

A comprehensive, coordinated policy approach is essential to ensure that mothers are supported in their decision to breastfeed and have the necessary resources, information, and social support to succeed.

In Europe, policies need to focus on health systems, workplace support, public education, and community-based programs to create an enabling environment that encourages and facilitates breastfeeding.

To protect mothers and babies from marketing practices that undermine breastfeeding, it is important to adjust national legislation on the provisions and recommendations of the International Code of Marketing of Breastmilk Substitutes and related World Health Assembly resolutions, to scale up breastfeeding programs and to encourage adoption of supportive legal instruments and protective policies at the regional/country levels.

National breastfeeding programs should be developed and integrated into public health initiatives, with a focus on education, counseling, and practical support for all mothers.

Community-based breastfeeding education and support groups should be established, including peer support networks, and ensure that information is available in multiple languages to meet the needs of diverse populations.

Breastfeeding education has to be as part of prenatal care and postnatal services, with trained health professionals providing guidance on latching, feeding techniques, and addressing challenges such as sore nipples, low milk supply, and breastfeeding in public.

Maternity leave policies allow sufficient time for mothers to initiate and continue breastfeeding without the pressure of returning to work too soon. WHO recommends at least six months of exclusive breastfeeding, and paid leave should reflect this recommendation. It is recommended to provide incentives for workplaces to adopt breastfeeding-friendly policies and encourage employers to create a supportive environment for breastfeeding employees.

It is necessary to adopt laws that protect the right of mothers to breastfeed in public spaces, including parks, shopping centers, and public transportation. These policies should encourage a non-discriminatory environment where mothers are not ashamed for breastfeeding in public.

2.1.2. Micronutrient supplementation

Public health problem

Micronutrients are only needed in very small quantities but are essential for normal physiological function, growth and development. Deficiencies of micronutrients such as vitamin A, iron, iodine and folate are particularly common among during pregnancy, due to increased nutrient requirements of the mother and developing fetus. These deficiencies can negatively impact the health of the mother, her pregnancy, as well as the health of the newborn baby.

Anaemia, most commonly due to iron deficiency, is a common problem in pregnant women worldwide, affecting nearly 50% of pregnancies globally, and children under 5 years old, in both developing and developed countries, but being worst in low- and middle-income countries.

Anaemia is associated with maternal morbidity, including impaired quality of life, a need for blood transfusions, post-partum haemorrhage, and maternal mortality. In addition, anaemia is associated with adverse fetal outcomes such as preterm birth, small for gestational age, and perinatal death. Impaired neurodevelopmental outcomes of the child have also been reported in some studies. The latest data shows that in the Europe region the anaemia affects an estimated 18.8% of women of reproductive age. Some 6.5% of infants have a low weight at birth. Table 2 shows the prevalence of anaemia among women of reproductive age in Europe. Poor maternal nutrition or unresolved health problems are the causes of low birth weight in newborns (this indicator is also presented in table 2).[12]

Table 2. Anaemia prevalence among women of reproductive age (15 - 49 years) and rate of infants with low weight at birth, %.

	%, women aged 15 to 49 years with anaemia	%, infants with low weight at birth
Albania	24.8	4.6
Andorra	12.1	7.4
Armenia	17.3	9.0
Austria	13.0	6.5
Azerbaijan	35.1	7.3
Belgium	13.6	7.3
Bosnia and Herzegovina	24.4	3.4
Bulgaria	23.6	9.6
Croatia	21.0	5.1
Czech Republic	21.1	7.8
Cyprus	13.6	no data
Denmark	12.2	5.3
Estonia	21.7	4.3
Finland	10.9	4.1
France	10.6	7.4
Germany	11.7	6.6
Georgia	27.5	6.1
Greece	15.1	8.7
Hungary	19.7	8.8
Iceland	10.3	4.2
Ireland	12.1	5.9

[12] https://globalnutritionreport.org/resources/nutrition-profiles

Italy	13.6	7.0
Latvia	21.6	4.5
Lithuania	19.9	4.5
Luxembourg	10.2	6.5
Malta	13.7	6.3
Moldova	26.1	5.0
Monaco	no data	5.4
Montenegro	17.2	5.5
Netherlands	12.8	6.2
Norway	12.0	4.5
North Macedonia	19.3	9.1
Poland	25.7	5.9
Portugal	13.2	8.9
Romania	22.7	8.2
San Marino	no data	3.3
Serbia	22.8	4.5
Slovakia	23.5	7.6
Slovenia	21.8	6.1
Spain	13.4	8.3
Sweden	13.6	2.4
Switzerland	11.3	6.5
UK and Northern Ireland	11.1	7.0
Ukraine	17.7	5.6

The prevalence of anemia appears to decrease with an increase in the educational level of the pregnant women. Women with a high school education or higher are less likely to acquire anemia during pregnancy, probably due to adequate micronutrient intake and health education. Poverty is another problem associated with anemia, and for this reason, social efforts need to be taken to guarantee a minimum food intake every day, as well as food fortification. Once this barrier has been trespassed, efforts such as campaigns should be undertaken to motivate women to often get medical follow-ups, get healthy food intake, and take multiple micronutrient supplements when required to decrease anemia, especially before pregnancy, to guarantee adequate levels. During pregnancy, such care is really important to avoid complications, especially those associated with children's development and the mother's outcomes [13]

In some settings, considerable reductions in the prevalence of anaemia have been achieved; however, overall, progress has been insufficient. Further actions are required to reach the World Health Assembly target of a 50% reduction of anaemia in women of reproductive age by 2025[14].

While the causes of anaemia are variable, it is estimated that about 50% are due to iron deficiency.

Vitamin A supplementation

Vitamin A deficiency is the leading cause of preventable childhood blindness and increases the risk of death from common childhood illnesses such as diarrhea. Periodic, high-dose vitamin A supplementation is a proven, low-cost intervention which has been shown to reduce all-cause mortality by 12 to 24 per cent and is therefore an important program in support of efforts to reduce child mortality. The World Health Organisation has classified vitamin A deficiency as a public health problem affecting about one-third of children aged 6 to 59 months (2013)[15].

[13] Araujo Costa E, de Paula Ayres-Silva J. Global profile of anemia during pregnancy versus country income overview: 19 years estimative (2000-2019). Ann Hematol. 2023 Aug;102(8):2025-2031. doi: 10.1007/s00277-023-05279-2.
[14] World Health Organization. Global nutrition targets 2025: anaemia policy brief. https://www.who.int/publications/i/item/WHO-NMH-NHD-14.4
[15] UNICEF Data: Monitoring the situation of children and women. https://data.unicef.org/topic/nutrition/vitamin-a-deficiency/

The situation deteriorated sharply following the March COVID-19 outbreak, primarily due to service delivery disruptions caused by pandemic containment measures. Based on administrative data analyzed by UNICEF, there was a 19-percentage point drop in two-dose vitamin A supplementation coverage from 2019 (61 per cent to 42 per cent), with 62 million fewer children receiving both doses in 2020. It is also clear that children with the greatest need for supplementation, those living in countries with the highest child mortality rates, had the largest drop and lowest coverage in 2020.

First targeted by global initiatives such as the World Summit for Children (1990), VAD control continues to be an important part of an intervention package to reduce preventable deaths, a key Sustainable Development Goal. To thwart the public health consequences of deficiency, the World Health Organisation (WHO) currently recommends that periodic, high-dose vitamin A supplements of 100,000 international units (IU) be given to infants aged 6–11 months and 200,000 IU to children aged 12–59 months in high-risk areas. Ideally, children receive their first dose soon after they turn 6 months and get subsequent doses every four to six months until the last dose is administered between 54 and 59 months of age. As vitamin A supplementation (VAS) does not address the underlying causes of VAD and its effect is temporary, some countries are scaling up efforts to address dietary intake and other underlying causes of poor vitamin A status, such as repeated infections due to poor hygiene. However, these efforts have been insufficient to entirely eliminate the need for supplementation. Through collaborative efforts with partners, the United Nations Children's Fund (UNICEF) plays a leading role in supporting countries to reach children aged 6–59 months with two appropriately spaced high-dose vitamin A supplements each year.

Iodine supplementation

Iodine is an element that is essential for normal growth, and for brain development. Iodine is especially important before birth and in babies and young children. It is essential for the development of the brain and nervous system, the 5 senses, alertness and coordination. Iodine deficiency is the most common worldwide cause of preventable mental retardation. Too little iodine is a risk factor for hypothyroidism (underactive thyroid). Low iodine levels can increase the risk of miscarriage. It can also lead to poor growth and intellectual disability in the baby. An adequate iodine intake during pregnancy, lactation and early childhood is particularly critical for optimal brain development of the foetus and of children 7–24 months of age. While the primary strategy for sustainable elimination of iodine deficiency remains universal salt iodisation, the World Health Organization and the United Nations Children's Fund recommend a complementary strategy of iodine supplements as a temporary measure when salt iodisation could not be implemented.

In most countries, the best strategy to control iodine deficiency is carefully monitored iodisation of salt. The reach of current iodised salt programmes is remarkable: in 2018, 88 % of the global population used iodised salt. The number of countries with adequate iodine intake has nearly doubled over the past 20 years from 67 in 2003 to 118 in 2020. The resulting improvement in cognitive development and future earnings suggests a potential global economic benefit of nearly $33 billion. Iodine programmes are appealing for national governments because the health and economic consequences are high and can be easily averted by salt iodisation, a low-cost and sustainable intervention. In 2020, 124 countries had legislation for mandatory salt iodisation and twenty-one had legislation allowing voluntary salt iodisation. The reach of current iodised salt programmes is remarkable. UNICEF estimates that, based on

data collected during the period 2013–2018, 88 % of the global population was using iodised salt in 2018[16].

Survey results

Various programs to provide children and pregnant women with micronutrients are implemented in the jurisdictions included in the study. Most of them provide iodised salt, folic acid, and iron.

> *"One of the specific objectives of the National Program for the Prevention of Priority Noncommunicable Diseases is to promote healthy nutrition at all ages. Examples of actions outlined in the program include universal use of iodized salt and bread made from flour fortified with iron and folic acid, especially among vulnerable population groups (children aged 6-12 years, pregnant and breastfeeding mothers)."*
>
> People's Advocate for child's rights, Republic of Moldova
>
> #
>
> *"Free vitamins are available for all pregnant women, containing Vitamins C and D and Folic Acid. Iron supplements are available free for those who need them. Bread and flour are fortified with folic acid. Vitamin D drops are available free for children under 3. Vitamin D deficiency is the most significant issue in Scotland due to limited winter daylight. Iodised salt is available, but iodine deficiency is not considered high risk in the UK."*
>
> Children and Young People's Commissioner, Scotland
>
> #
>
> *"In Norway, the prevention of micronutrient deficiencies is a key component of national public health policy, guided by evidence-based recommendations outlined in national infant and young child nutrition guidelines. These guidelines are implemented through the country's universal and free Child and Family Health Centers (CFHCs) and maternal health services, ensuring equitable access for all families. During pregnancy, attention is given to preventing deficiencies in folic acid, iodine, and iron, all of which are essential for fetal development and maternal well-being. Pregnant women receive individualised advice and follow-up from midwives, who assess their nutritional needs".*
>
> The Ombudsman for Children, Norway

However, 6 out of 27 jurisdictions reported that they do not have any such programs. Accordingly, the emphasis is not placed on prevention, but on treating symptoms, in case they appear with various deficiencies.

> *"Specific treatments may be prescribed in case such deficiencies are detected during ordinary or extraordinary health controls but we have no general and permanent preventive programs in place".*
>
> The Ombudsman's Office, Andalusia/Spain

Policy level approach

WHO recommends antenatal iron and folic acid supplements containing 60 mg of elemental iron in populations where anaemia is a severe public health problem (a prevalence of 40% or higher). Therefore, countries should consider their population magnitude and distribution of anaemia, its nutritional determinants (i.e. iron deficiency), as well as the magnitude and distribution of the complex low birthweight and its component parts (i.e. preterm, small for gestational age or a combination of these)[17].

At the same time, WHO/Europe and the Iodine Global Network urgently call for iodine fortification of salt and plant-based dairy alternatives. Countries need more flexible policy strategies to protect people

[16] Zimmermann MB. The remarkable impact of iodisation programmes on global public health. *Proceedings of the Nutrition Society*. 2023;82(2):113-119. doi:10.1017/S0029665122002762

[17] WHO antenatal care recommendations for a positive pregnancy experience Nutritional interventions update: Multiple micronutrient supplements during pregnancy. https://www.who.int/publications/i/item/9789240007789

from iodine deficiency, including mandatory policies for the use of iodized food-grade salt in processed foods and integration of salt reduction and salt iodization measures. Considering the change in dietary landscapes, there is also a need to ensure appropriate fortification of alternative milk and dairy products with iodine.[18]

2.1.3. Child Malnutrition

Public health problem

Stunting is the result of chronic or recurrent undernutrition in-utero and early childhood. Children suffering from stunting may never reach their full possible height nor their full cognitive potential. Stunted children not only earn less as adults as a result of less schooling and learning difficulties when in school, but they are also more likely to be at risk of overweight and obesity than children of normal height.

Wasting is a life-threatening condition attributable to poor nutrient intake and/or disease. Characterized by a rapid deterioration in nutritional status over a short period of time, children suffering from wasting have weakened immunity, increasing their risk of death due to greater frequency and severity of common infection, particularly when severe.

Different regions of Europe have different rates of child malnutrition, which vary significantly, from the lowest - 1.5, to the highest being 8.7 (in 2022). However, it is worth noting that in the countries of the European region, a consistent trend of decreasing the rate of malnutrition is being determined (table 3).

Table 3. Stunting prevalence 2012- 2022 (%, lower bound - upper bound)[19]

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Europe	**5.1** 3.7 – 6.9	**5.0** 3.6 - 6.8	**4.9** 3.6 – 6.6	**4.8** 3.5 – 6.6	**4.7** 3.4 – 6.5	**4.6** 3.4 – 6.6	**4.5** 3.3 – 6.2	**4.4** 3.2 – 6.1	**4.3** 3.1 – 5.9	**4.1** 3.0 – 5.7	**4.0** 2.9 – 5.4
Eastern Europe	**7.2** 4.5 –11.3	**7.0** 4.4 –11.0	**6.8** 4.3 – 10.7	**6.7** 4.1 – 10.7	**6.6** 4.0 – 10.5	6.4 3.9 – 10.4	**6.2** 3.8 – 10.1	**6.0** 3.6 – 9.9	**5.8** 3.5 – 9.5	**5.6** 3.3 – 9.3	**5.3** 3.2 – 8.7
Northern Europe	**3.7** 1.8 –7.3	**3.5** 1.8 – 6.9	**3.5** 1.7 – 6.8	**3.4** 1.7 – 6.6	**3.3** 1.7 – 6.4	**3.2** 1.7 – 6.1	**3.2** 1.6 – 6.1	**3.1** 1.6 – 6.1	**3.1** 1.6 – 5.9	**3.0** 1.5 – 5.9	**3.0** 1.5 – 5.8
Southern Europe	**4.6** 2.8 –7.5	**4.5** 2.7 – 7.4	**4.5** 27 – 7.2	**4.4** .7 – 7.2	**4.4** 2.7 – 7.0	4.3 2.7 – 6.9	**4.2** 2.6 – 6.7	**4.1** 2.6 – 6.7	**4.1** 2.5 – 6.5	**4.0** 2.4 – 6.5	**3.9** 2.4 – 6.3
Western Europe	**2.8** 1.5 –4.9	**2.7** 1.5 – 4.9	**2.7** 1.6 – 4.7	**2.7** 1.6 – 4.6	**2.7** 1.5 – 4.6	**2.6** 1.6- 4.4	**2.6** 1.6 – 4.3	**2.6** 1.6 – 4.2	**2.6** 1.6 – 4.2	**2.6** 1.6 – 4.1	**2.6** 1.6 – 4.2

Some countries/regions participating in the survey noted high targets achieved by their jurisdiction constantly having a low level of child malnutrition.

"Comprehensive data on children's malnutrition indicators in Iceland over the past five years is limited. According to the Global Nutrition Report, Iceland is 'on course' to meet the global target for reducing low birth weight, with 4.2% of infants having a low weight at birth."

The Ombudsman for Children, Iceland

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"*Malnutrition is so rare in Finland that it is not recorded in statistics*."

Office of the Ombudsman for Children, Finland

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"*The prevalence of undernourishment in Ireland continued to be estimated to be less than 2.5% in 2021".*

[18] https://www.who.int/europe/news/item/28-06-2024-people-in-the-who-european-region-at-greater-risk-of-iodine-deficiency-due-to-changing-diets

[19] UNICEF, WHO, World Bank Group Joint Malnutrition Estimates, 2023. https://data.unicef.org/topic/nutrition/malnutrition/

However, in some countries/regions, high rates of malnutrition are still recorded and a lot of children under 5 years of age are still affected. Table 4 presents data on stunting and wasting rates of children under 5 years of age in some European countries. We selected the countries where the rate of stunting exceeds the average for the European region (4.0). It should be noted that the list is not complete, as for many countries there is no data available to calculate this indicator. The data are selected from the Global Nutrition Report site[20].

Table 4. Stunting and wasting prevalence in children under 5 years of age in some ENOC member jurisdictions and other European countries, %.

	children under five are stunted	children under five are wasted
Albania	11.3	1.6
Armenia	9.4	4.4
Azerbaijan	17.8	3.2
Bosnia and Herzegovina	8.9	2.3
Bulgaria	7.0	6.3
Georgia	5.8	0.6
Republic of Moldova	6.4	1.9
Montenegro	7.2	2.2
North Macedonia	4.3	3.4
Romania	12.8	3.5
Serbia	5.4	2.6
Ukraine	22.9	8.2

Policy level approach

Child malnutrition is vital for tackling one of the most pressing issues impacting children's health, development, and well-being. Recognizing that accelerated global action is needed to address the pervasive and corrosive problem of the double burden of malnutrition, in 2012 the World Health Assembly Resolution 65.6 endorsed a Comprehensive implementation plan on maternal, infant and young child nutrition, which specified a set of six global nutrition targets that by 2025 aim to: achieve a 40% reduction in the number of children under five who are stunted; achieve a 50% reduction of anaemia in women of reproductive age; achieve a 30% reduction in low birth weight; ensure that there is no increase in childhood overweight; increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%; reduce and maintain childhood wasting to less than 5%.

Addressing malnutrition requires a multi-sectoral, comprehensive approach that involves health systems, agriculture, education, social protection, and environmental policies. National policies should ensure universal access to affordable, nutritious food for all children, especially those in vulnerable or marginalized groups, such as children in low-income families, migrants, or refugees.

Nutrition services should be integrated into the broader primary healthcare system, where healthcare workers can monitor nutritional status, provide nutritional counseling, and refer families to food assistance programs when needed. School meal programs have to be expanded to provide healthy, balanced meals to children, particularly in schools with high proportions of children from low-income households. Poverty, which is one of the primary drivers of malnutrition, should be reduced through

[20] https://globalnutritionreport.org/resources/nutrition-profiles/

social protection policies such as universal child allowances, food assistance programs, and targeted subsidies for low-income families.

2.1.4. Obesity and overweight

Public health problem

Nearly half of all deaths in children under 5 are attributable to undernutrition but the face of malnutrition, in all its forms, is rapidly changing, with childhood overweight an escalating epidemic of global proportions. Overweight is the result of a growing number of children living in obesogenic environments with greater availability of processed foods and a more sedentary lifestyle.

In 2022, 37 million children under the age of 5 were overweight. Over 390 million children and adolescents aged 5–19 years were overweight in 2022, including 160 million who were living with obesity. The prevalence of overweight (including obesity) among children and adolescents aged 5–19 has risen dramatically from just 8% in 1990 to 20% in 2022. While just 2% of children and adolescents aged 5–19 were obese in 1990 (31 million young people), by 2022, 8% of children and adolescents were living with obesity (160 million young people). Once considered a high-income country problem, overweight is on the rise in low- and middle-income countries[21].

Survey results

This was also confirmed by some participants of the survey.

"Between 2014 and 2022, overweight and obesity increased from 15% to 22% among boys, and from 11% to 16% among girls in Luxembourg. In 2022, about one in five 11–12-year-olds were overweight (including obesity), with a higher prevalence among boys. In addition, the increase since 2010 was more pronounced among boys than girls. Children with no migration background had a lower prevalence (15.8%) of overweight or obesity than children who had migrated (20.6%) and those whose parents had migrated (20.5%). The National Health Observatory, in 2024 report drew our attention to the challenge of lack of physical activity, obesity and social inequalities and their consequences on the health of children and young people[22]. Fruit and vegetable consumption are less common in Luxembourg than in most other EU countries: in 2019, only 14 % of adults reported eating at least five portions of fruit and vegetables every day, a share that has slightly declined since 2014. Altogether, in 2022, about 30 % of 15-years-olds reported that they consume a fruit or vegetable on a daily basis. Children from poorer backgrounds are less likely to report behaviours that are good for their health. Daily fruit and vegetable consumption was reported by 39% of children from richer households compared with 18% for those from poorer households.

Low physical activity also contributes to weight problems. Only 13 % of 15-year-olds reported doing at least moderate physical activity every day – a lower proportion than the EU average (15 %).

Ombudsman for Children and Adolescents (OKAJU), Luxembourg

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"*Recent data indicates a concerning rise in childhood obesity in Iceland. Historically, the prevalence of childhood obesity remained around 5%. However, over the past six years, this figure has increased to*

[21] World Health Organization. Obesity and overweight https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

[22] OKAJU report on Health 2023 Health system review report of 2024. Available at: https://obs.gouvernement.lu/fr/publications.gouv2024_obs%2Bfr%2Bpublications%2Bluxembourg-health-system-review-2024.html

7.5%, affecting nearly 5,000 children. Additionally, in 2022, over 21% of 15-year-olds in Iceland were classified as overweight or obese, a rate slightly higher than the European Union average"[23].

The Ombudsman for Children, Iceland

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" *The prevalence of overweight was 26% in boys aged 2–16 and 17% in girls in 2023. Since 2014, the prevalence of overweight (including obesity and severe obesity) has increased by approximately one percentage point in boys aged 2–16 and one and a half percentage points in girls. When examining changes in the prevalence of overweight over time, it is important to take into account the shortcomings and changes in the registry data. There are problems with the comprehensiveness of the data. In addition, annual health checks for children were not carried out during the pandemic*."

Office of the Ombudsman for Children, Finland

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"According to a survey conducted in Croatia, under the name Childhood Obesity Surveillance Initiative (COSI), in 2015/2016 the proportion of children with overweight and obesity was 34.9%, in 2018/19 this proportion was 35.0%, and in the third round, i.e. 2021/2022 it increased to 36.1%. In this sense, the Republic of Croatia is not on track to achieve one of the WHO goals aimed at global prevention of chronic non-communicable diseases, which is to stop obesity by 2025. In fact, according to the results of previous rounds of COSI research, Croatia was at the very top of Europe, along with other Mediterranean countries. For 2021/2022 malnutrition was recorded in 1.4% of children."

Ombudsman for Children, Republic of Croatia

In most cases obesity is a multifactorial disease due to obesogenic environments, psycho-social factors and genetic variants. In a subgroup of patients, single major etiological factors can be identified (medications, diseases, immobilization, iatrogenic procedures, monogenic disease/genetic syndrome).

The obesogenic environment exacerbating the likelihood of obesity in individuals, populations and in different settings is related to structural factors limiting the availability of healthy sustainable food at locally affordable prices, lack of safe and easy physical mobility into the daily life of all people, and absence of adequate legal and regulatory environment.

At the same time, the lack of an effective health system response to identify excess weight gain and fat deposition in their early stages is aggravating the progression to obesity.

It is worth appreciating the fact that some countries have started to implement concrete tools for monitoring weight indicators in children, such as the case of Norway.

"Weight data is the area where we have the "poorest data" in Norway. The Norwegian Institute of Public Health (FHI) has now established a system where health stations and school health services will report data to the Municipal Patient and User Data (KPR). Municipalities will be obligated to report data starting in the autumn of 2025."

The Ombudsman for Children, Norway

Childhood and adolescent obesity have adverse psychosocial consequences; it affects school performance and quality of life, compounded by stigma, discrimination and bullying. Childhood obesity also can lead to poor self-esteem and depression. Children with obesity are very likely to be adults with obesity and are also at a higher risk of developing NCDs in adulthood. The extra weight often starts children on the path to other health conditions such as diabetes and high blood pressure.

[23] https://www.oecd.org/en/publications/iceland-country-health-profile-2023_f2868adb-en.html

Practically, all responding institutions listed various documents adopted in their jurisdictions to reduce harmful eating behaviors of children, especially in schools and kindergartens. The mentioned interventions are focused on promoting healthy eating practices in schools by encouraging balanced, age-appropriate meals, to limits children's access to unhealthy foods, sugary or energy drinks, nutrient-poor products, as well as restricting marketing or sale of such products to children.

"*There is a Monitoring System for Nutrition Practices of Children 0-5 Years Old in Albania. In the framework of promoting healthy eating habits in children, the Ministry of Health and Social Protection, in cooperation with the Ministry of Education and Sports, has approved and implemented the regulation "On the prohibition of advertising unhealthy foods in the premises of educational institutions of basic education". This act aims to create a healthier environment in schools and reduce the impact of advertising of unhealthy foods on children*."

The People's Advocate, Albania

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"Since the issue of student nutrition has not yet been resolved in secondary schools, the installation of vending machines is permitted. However, the contract and permit for installing the machine are issued by the school principal, who must influence the contents of the machine, which is regulated by the contract. Principals should not allow the sale of anything harmful to students' health in school premises. Vending machines with snacks, sweets and sweet drinks are generally not recommended in schools. If any primary or secondary school in the Republic of Croatia has a vending machine with food and drinks, it is necessary to offer food products recommended by the Croatian Institute of Public Health and avoid those that are not recommended for sale in school vending machines. In addition, energy drinks should not be available in vending machines. We are not satisfied with the implementation and monitoring of this recommendation. Near some schools, we see vending machines with unhealthy food and drinks that are affordable for children. The consumption of energy drinks is also quite widespread among children, which we continuously warn about. Children and parents are not sufficiently aware or do not pay enough attention to information about the potential harm of consuming energy drinks to children's health. There is a lot of room for improvement in practices related to proper child nutrition."

The Ombudsman for Children, Republic of Croatia

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"In Italy there are several programmes and policies at national and regional level that promote healthy eating among minors, with a focus on the prevention of childhood obesity and the promotion of healthy lifestyles. These programmes involve not only children, but also families and schools, in order to create a culture of healthy eating that lasts over time. Italy has implemented several initiatives and programmes at national and regional level to promote healthy eating habits among minors. These include nutrition education in schools, promoting healthy food choices, limiting advertising of unhealthy foods and regulating access to energy-dense, nutrient-poor foods."

The Authority for Children and Adolescents, Italy

Healthy children's feeding is about effective intersectoral approaches. Some survey respondents noted such positive practices in their jurisdictions. An example of good practice from Poland illustrating an effective intersectoral approach to protecting children's health and promoting healthy lifestyles.

"The Nationwide Program "Keep Fit!", the „Meal at School and at Home" and the "School Program" initiatives represent good intersectoral practices aimed at improving children's health and promoting a healthy lifestyle in Poland. These programs involve multiple sectors, including: Ministry of Health, Ministry of Education and Science, Ministry of Family and Social Policy, Ministry of Agriculture and Rural Development, Local governments and municipalities, Educational institutions (schools,

kindergartens), National Health Fund (NFZ), Local NGOs and civil society organizations Key activities and characteristics of these initiatives include: Providing free, nutritious meals to children at schools, especially focusing on students from economically disadvantaged families. Offering regular distribution of fresh fruit, vegetables, and dairy products in schools to promote healthy eating habits. Organizing educational activities, lessons, workshops, and campaigns on nutrition, physical activity, obesity prevention, and overall healthy lifestyles among children, parents, and teachers. Systematic cooperation between schools, local authorities, public healthcare institutions, non-governmental organizations, and local communities. Results and impact: Improved nutritional status and reduced risk of malnutrition among children from vulnerable groups. Increased awareness among children and families about healthy dietary habits and physical activity. Effective cooperation between education, healthcare, agriculture, and social welfare sectors, resulting in measurable improvement in child health outcomes. These programs have demonstrated the effectiveness of intersectoral cooperation in addressing health-related challenges faced by children and promoting long-term positive changes in their lifestyle and well-being in Poland. "

The Ombudsman for Children, Poland

Children nutrition in schools

School-age children (ages 6 to 12) need healthy foods and nutritious snacks. Every day, over 100 million children in low- and lower-middle-income countries are going hungry. Millions go to school on an empty stomach – hunger affects their concentration and ability to learn. School meal programmes can help address many of these challenges. Schools are in a unique position to help students learn about and practice healthy eating behaviors, such as: eating a healthy breakfast and drinking enough water. Nutrition of school-age children is a core component of its child-centered programmes. To reach children of this age group, schools are a proven platform for the delivery of nutrition interventions (i.e., nutrition education, counselling, support, and services). Schools offer additional benefits for nutritional outcomes, as they can promote nutritious diets and impart related knowledge through skills-based education, especially when they are supported by supportive policies that help create enabling environments for the awareness of good nutrition principles.

The **European Child Guarantee,** was adopted on 14 June 2021 with the objective to prevent and combat social exclusion by guaranteeing effective access of children in need to a set of key services: 1) free early childhood education and care; 2) free education (including school-based activities) 3) school meals (at least one healthy meal each school day); 4) free healthcare; 5) healthy nutrition, and 6) adequate housing. A report (2023) examines the extent to which the six key services covered by the European Child Guarantee are readily available and accessible as well as free or affordable to children in low-income households across the EU. The report established that **more than two-thirds of the EU countries fail to provide free school meals to low-income children** in compulsory education. Inadequate benefits, low salaries, and, more broadly, insufficient discretionary income (i.e. the money remaining after taxes and essential household bills have been paid) **hamper the access of low-income children to healthy nutrition**. The situation is aggravated by the high(er) price of healthy food and by inflation in general.[24]

[24] https://employment-social-affairs.ec.europa.eu/news/new-report-published-access-children-need-european-child-guarantee-key-services-2023-09-20_en#:~:text=Healthcare:%20In%20most%20EU%20countries%2C%20all%20children,similar%20for%20specialist%20care%20and%20dental%20care.

Access to healthy and sustainable nutrition is a challenge for low-income families in particular. Healthy food and nutrition programmes can help address problems such as poor diet, lack of physical activity, obesity or use of alcohol and tobacco, thereby reducing malnutrition and poor nutrition, which is more prevalent among children from disadvantaged backgrounds. The experience of the COVID-19 pandemic demonstrated the importance of school meal schemes for some children, who were suddenly deprived of a reliable source of nutrition during lockdown. Ensuring access of children in need to at least one healthy meal each school day is therefore paramount and could be achieved either by providing such meals or by ensuring that parents or guardians, or children, are in a position to cater for the meals, taking into account specific local circumstances and needs[25].

In the jurisdictions included in the study, we determined diverse approaches to the problem of child nutrition in schools. In 5 jurisdictions out of 27 (18.5%) there are no such provisions at all. In 7 jurisdictions (25.9%) there are public programs that only partially cover children's meals, and in 5 jurisdictions (18.5%) only children from vulnerable families are provided with meals from public funds. School meals are fully covered by the state budget or by local authorities for all ages only in 4 jurisdictions (14.8%), and in 6 jurisdictions (22.3%), school meals are covered by the public budget only for primary classes.

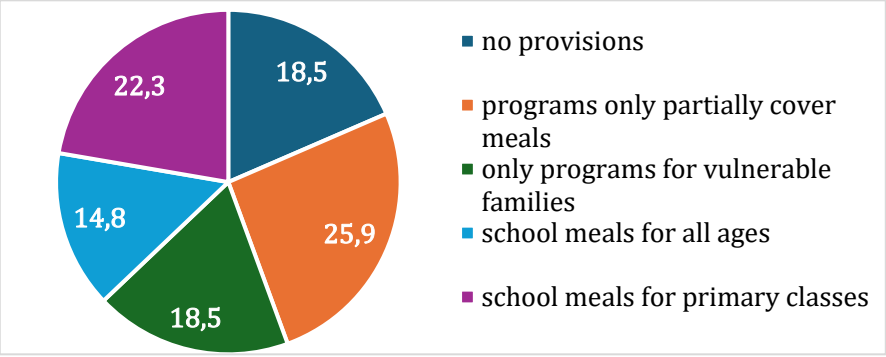

Figure 9. Programs to ensure accessible nutrition for children in schools, 27 jurisdictions, %

"The NI Education Authority Catering Service provides school meals and catering for over 1,030 primary schools, post-primary schools, special schools and nurseries across NI. These must be purchased by the child. Unlike elsewhere in the UK, where universal FSM are provided to pupils in certain year groups (in England, Scotland, and Wales), this is not the case in NI. There is provision for free school meals ("FSM"), but FSM are only available to those pupils who meet a set of eligibility criteria. If none of the established criteria apply and a child presents at school hungry, the school should, on humanitarian grounds, provide free school meals to the child. The school should then make a referral to the Education Authority's Education Welfare Service. "

Commissioner for Children and Young People, Northern Ireland

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" *This is regulated in the Education Act, which states that "Pupils shall be offered nutritious school meals free of charge".*

Office of the Ombudsman for Children, Sweden

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[25] European Child Guarantee. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32021H1004#PP2Contents

"*School meals are covered by the public budget for primary classes and children from vulnerable families."*

The Parliament Commissioner for Human Rights, Ukraine

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"*In Scotland, children from low-income families are entitled to free school meals, however not all families in poverty qualify. The Scottish Government is in the process of extending provision of universal free school meals to all primary school children, with the first 5 years currently provided with a school lunch in all local authorities and an extension to all 7 years of primary school and the first 3 years of secondary school*."

Children and Young People's Commissioner, Scotland

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"*In primary education, school catering is generally managed by municipalities and overseen by the Caisse des écoles, which provides input on pricing and menu composition. The financial contribution of families is determined by the municipality based on the family quotient and their salary. Families facing financial difficulties can contact the territorial social worker for assistance. In secondary education, meal prices are set by the relevant local authority. The School Meal Social Fund (Fonds social pour les cantines) can provide financial assistance to families. Article 186 of Law No. 2017-86 of January 27, 2017, on equality and citizenship introduced a new Article L. 131-13 into the Education Code, which states: "Enrollment in primary school cafeterias, where such a service exists, is a right for all enrolled children. No discrimination may be made based on their situation or that of their family." This legislative innovation, reflecting the evolving role of school cafeterias and the societal debates surrounding them, has strengthened the legal framework governing school catering. At the same time, administrative case law has also evolved in parallel. However, certain forms of discrimination persist regarding access to school cafeterias. While catering services are a mandatory public service in secondary education, they remain an optional public service in primary education. Unlike departmental and regional councils, which are required to provide this service in middle schools (collèges) and high schools (lycées), municipalities retain the discretion to decide whether to offer school meal services in primary schools."*

Office of the Rights Defender, the Children's Defender (France)

In order to have a healthy diet for children in schools, it is very important to monitor the nutritional value and quality of the food offered to children. From the survey, we observe that only in 15 jurisdictions out of 27 the menus are strictly monitored by nutrition specialists and are approved in strict accordance with the regulations in force regarding children's nutrition. Mostly, the menus are composed based on the financial capabilities of the educational institutions, according to the funding they receive, or there are different local specific approaches.

"According to the NI Education Authority, school menus are developed to "ensure that they incorporate customers 'likes and dislikes' as well as considering nutritional balance, cost and variety." The Education Authority states that schools must take a 'whole school approach' to all the food and drink that is provided and consumed in school and develop children and young people's skills and knowledge in relation to healthy eating and lifestyles outside of school. 'Healthy Food for Healthy Outcomes - Food in Schools Policy', a joint Department of Education and Department of Health document, collates several existing strategies that are being put in place to deliver improved nutrition for school children. The policy introduces a "whole school" approach to food in schools, so that children and young people receive a consistent message not only in what they are taught in the classroom about healthy eating,

but also in the food that is available to them in the canteen, vending machines and tuck-shops within their school."

Commissioner for Children and Young People, Northern Ireland

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"*In Italy, there are a number of regulatory provisions, national programmes and local initiatives that promote access to healthy food in schools, with the aim of ensuring that all minors have access to balanced and nutritionally adequate meals. School food policies focus not only on the accessibility of meals, but also on nutrition education as a tool to prevent health problems, such as childhood obesity, and to promote long-term healthy eating habits*."

The National Authority for Children and Adolescents, Italy

Policy level approach

Childhood obesity not only affects children's immediate health but also has long-term consequences, including an increased risk of chronic diseases such as type 2 diabetes, cardiovascular diseases, and even some cancers in adulthood. Given the rising rates of childhood obesity across the European region, addressing this issue requires a multi-faceted, coordinated approach that includes prevention, early intervention, and treatment**.** These efforts should be driven by policy at the national, regional, and local levels, supported by healthcare systems**,** education**,** social services**,** food systems**,** and urban planning**.**

Stopping the rise in obesity demands multisectoral actions such as food manufacturing, marketing and pricing and others that seek to address the wider determinants of health (such as poverty reduction and urban planning). Such policies and actions include:

- adopt policies, structural, fiscal and regulatory actions aimed at creating and foster healthy food environments;
- improve the availability and affordability of nutritious foods, make healthier food options available, accessible and desirable for children in homes, day care, and early childhood development centres;
- safeguard children from consuming unhealthy foods and beverages;
- health sector responses designed and equipped to identify risk, prevent, treat and manage the disease. These actions need to build upon and be integrated into broader efforts to address NCDs and strengthen health systems through a primary health care approach;
- provide micronutrient supplementation as part of routine health services for children.

The government efforts should be focused on implementing a school-based multi-sectoral approach through the cooperation of the health and education sectors to address malnutrition among adolescents. NFSI has strengthened the involvement of adolescents, families, and community representatives and complemented ongoing school interventions by creating an enabling environment in schools for sustainable positive change regarding healthy nutrition and lifestyles.

2.2. Physical activities among children

Public health problem

Physical activity refers to all movement including during leisure time, for transport to get to and from places, or as part of a person's work or domestic activities. Both moderate- and vigorous-intensity physical activity improve health. Popular ways to be active include walking, cycling, wheeling, sports, active recreation and play, and can be done at any level of skill and for enjoyment by everybody. In

accordance with the guidance documents of the World Health Organization, the European Union and its Member States recommend a minimum of 60 minutes of daily moderate-intensity physical activity for children and young people[26] . The global estimates indicate that over 80% of young people in school are not meeting this global recommendation of physical activity per day. In most countries, girls are less active than boys, and levels of inactivity among girls have not improved since 2001 (in fact, the gap between girls and boys is widening). In addition, the most socially disadvantaged groups in most countries, such as girls and those living with chronic health conditions or disability, are often the least active[27].

In children and adolescents, regular physical activity is associated with improved physical fitness, cardiometabolic health, bone health, cognitive outcomes, mental health and reduced body fat. Most of the daily physical activity should be aerobic. Vigorous-intensity activities should be incorporated, including those that strengthen muscle and bone, at least 3 times per week[28]. Evidence shows higher amounts of sedentary behaviour are associated with the following poor health outcomes: increased adiposity, poorer cardiometabolic health, reduced sleep duration.

Survey results

Many survey respondents provided extensive responses describing active programs in their jurisdictions aimed at promoting and supporting physical activity among children and adolescents.

"*The Sports Teams in Schools program, initiated by the Ministry of Education and Science and the Albanian Olympic Committee, aims to engage students in physical activities after the school day, enabling their participation in various sports, such as football, basketball, etc. The implementation of the program has created a healthy and competitive environment for students who seek to develop their talent in sports games related to physical health, the spirit of competition and teamwork, promoting the values of fair play and sports discipline.*"

The People's Advocate, Albania

#

"*There are also strategic documents aimed at the development of sports and sports infrastructure, such as: National Plan for Children's Rights in the Republic of Croatia, 2022-2026 (Strategic goal: Healthy, active and quality life, in which the implementation of the policy of healthy and active living is encouraged); National Sports Program 2019-2026 (Specific objectives: to encourage health-oriented physical exercise and to encourage universal sports school programs and to ensure the implementation of high-utility physical activity training); Government Program from 2024 to 2028 (one of the priorities is the promotion of amateur and professional sports); Parasports Development Strategy in the Republic of Croatia 2022-2030; Action Plan for the Prevention of Obesity 2024-2027 (includes measures to promote physical activity aimed at people at all stages of life and measures aimed at promoting physical activity aimed at infants, children and young people).*

The Ombudsman for Children, Republic of Croatia

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"*The Active School Program was launched by the Ministry of Sport and Tourism to enhance physical activity among children and youth. In its first year, over 5,600 schools introduced additional sports classes, engaging approximately 300,000 children in extracurricular sports. The program focuses on offering free sports sessions, weekend activities, and extracurricular programs. Several programs have been implemented to promote physical activity among children. Here are some examples:*

[26] EU Physical Activity Guidelines Recommended Policy Actions in Support of Health-Enhancing Physical Activity, Brussels, 2008.

[27] WHO. https://www.who.int/publications/i/item/9789240049567

[28] WHO. Global recommendations on physical activity for health. 2010.

1. "Trzymaj Formę!" Program: This nationwide program targets students in grades 5–8 of primary schools. The program utilizes project-based methods, engaging youth in activities that promote a healthy lifestyle.
2. "*Aktywna Szkoła" (Active School) Program: offers additional sports classes, outdoor activities, and various forms of competition. It also supports community integration through organizing sports events.*
3. "Mały Mistrz" (Little Champion) Program: designed for children in grades 1–3, encouraging physical activity through engaging physical education lessons. It helps children develop basic sports skills, contributing to their physical and social development.
4. "Szkolny Klub Sportowy" (School Sports Club) Program: aims to popularize sports and physical activity among children and adolescents. It offers nearly 100 different forms of activity, conducted twice a week in 60-minute sessions. The program also involves parents and teachers, promoting a healthy lifestyle.
5. "Sportowe Talenty" (Sporting Talents) Program: was launched by the Ministry of Sport and aims to assess children's physical abilities and assist sports clubs in identifying talented youth. These programs play a crucial role in promoting physical activity among Polish children, contributing to their health and overall development."

The Ombudsman for Children, Poland

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"*In Italy, several programmes and initiatives promote physical activity among minors:*

1. *'Sport di tutti': A national programme that makes sport accessible free of charge to minors, especially those with limited economic resources.*
2. *'I play at school': An initiative that encourages physical activity after school, with workshops and games in collaboration with schools and sports associations*."

The National Authority for Children and Adolescents, Italy

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"*At the regional level, we would like to mention two initiatives:*
1. The "Mentor 10" Program: it aims at promoting sport habits, an active lifestyle, as well as the values usually related to sport, such as fair play, the effort culture, respect to diversity and to the adversary. The program enrolls popular and successful sportsmen and women to lead training and informative activities both inside and outside schools where they will share their experience with children and young people, emphasizing the importance of an active lifestyle from the early childhood.
2. *There is an agreement between the Andalusian Regional Government and some local councils of the province of Almeria in order to grant free access of children from the alternative care system to public sports facilities. "*

The Ombudsman's Office, Andalusia/Spain

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"*A science-driven education innovation program "Schools in Motion" is implemented in Estonia. In collaboration with participating schools, the program aims to develop and implement practices that support physical activity of students and teachers in Estonia. Currently, 43% of all general education schools (almost 57 % of all pupils) in Estonia are involved in the program*[29]"

Office of the Chancellor of Justice, Child's and Youth Rights Department, Estonia

#

"*There is some Scottish Government funding for specific initiatives in school holidays*[30] *. Other services are funded through a mix of local authority and charitable grants. All 32 local authorities now support the Daily Mile initiative*[31]".

[29] see for more: https://www.liikumakutsuvkool.ee/english/
[30] https://www.gov.scot/news/help-for-families-during-holidays/
[31] https://www.gov.scot/news/scotland-is-worlds-first-daily-mile-nation/

Children and Young People's Commissioner, Scotland

#

"There is an agency responsible for promoting and developing sports in Malta - Sport Malta. Parents are also given a tax deduction for sending their children to sports activities after school."

Office of the Commissioner for Children, Malta

"*Launched at the start of the 2020 school year as part of the legacy measures for the Paris 2024 Olympics, the "30 Minutes of Physical Activity Daily" program has been implemented nationwide in all 36,250 primary schools since September 2022. Supporting this transformative initiative is one of the key priorities outlined in the strategic plans of the Ministry of Sports and the Olympic and Paralympic Games, as well as the Ministry of National Education and Youth. A Senate report indicates that 42% of schools have fully implemented the program for the majority of their students, whereas public authorities report a figure of 90%."*

The Children's Defender, Office of the Rights Defender, France

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"*After-School Programs: Every primary school in Iceland offers after-school programs providing a variety of recreational activities for children aged 6 to 9. These programs operate from the end of the school day until 5 pm during the academic year and offer full-day activities during the summer months. They aim to create a supportive environment for physical activity and social interaction. Sports Clubs and Associations: Numerous sports clubs across Iceland offer organized recreational activities for children and adolescents outside school hours. These clubs provide training and participation opportunities in various sports such as football, handball, basketball, and swimming. The National Olympic and Sports Association of Iceland coordinates many of these activities, promoting youth fitness and physical activity nationwide. Leisure Card Program: In Reykjavík, the Leisure Card program provides financial support to families, enabling children to participate in organized leisure activities, including sports and physical activities. This initiative aims to increase accessibility and encourage greater participation in physical activities among youth."*

The Ombudsman for Children, Iceland

Most respondents indicated that physical activity and sport among children and adolescents is a priority included in the policy documents and strategic plans of their jurisdiction/country. However, there were also a few responses, mentioning that this area is less developed or does not receive much attention from the authorities, being left to develop sporadically, without strategic approaches.

Policy level approach

The World Health Organization is encouraging countries to develop and implement policies aimed at increasing physical activity in children and adolescents. The purpose of this paper is twofold: (1) to identify the common existing international policies established to increase physical activity in children and adolescents; and (2) to examine the extent to which these policies are supported by solid scientific evidence. The policy areas found to be the most common were: (1) Physical Education in School; (2) Physical Activity-Related Health Education; (3) Community Environmental Support; (4) School Environmental Support; (5) Active Transport/Urban Design; and (6) Mass Media/Advertising Campaigns.

Implementing effective policies to increase levels of physical activity requires a collective effort, coordinated across multiple government departments at all levels, including health, transport, education, employment, sport and recreation, and urban planning. It also demands national and local engagement from nongovernmental organizations, various sectors, stakeholders and disciplines to support the implementation of policies and solutions that are appropriate to a country's cultural and social

environment. Priority should be given to policy actions that address disparities in levels of physical activity, promoting, enabling and encouraging physical activity for all.

2.3. Immunization coverage and vaccine-preventable diseases

Public health problem

Immunization is one of the most successful public health interventions to reduce child mortality and morbidity. However, immunization efforts are under growing threat as misinformation, population growth, humanitarian crises, and funding cuts jeopardize progress and leave millions of children, adolescents, and adults at risk.

Coverage has plateaued over the last decade. Outbreaks of vaccine-preventable diseases such as measles, meningitis, and yellow fever are rising globally, and diseases like diphtheria, which have long been held at bay or virtually disappeared in many countries, are at risk of re-emerging. In response, WHO, UNICEF, and Gavi calling the countries for urgent and sustained political attention and investment to strengthen immunization programmes and protect significant progress achieved in reducing child mortality over the past 50 years[32].

The COVID-19 pandemic, associated disruptions, and COVID-19 vaccination efforts strained health systems in 2020 and 2021, resulting in setbacks[33]. In 2023*, DTP (diphtheria, tetanus toxoid and pertussis-containing vaccine*) immunization coverage had not yet recovered to 2019 levels in all countries in Europe and Central Asia. Globally, DTP3 (third dose of DTP containing vaccine) immunization coverage among one-year-olds worldwide dropped from 86% in 2019 to 81% in 2021, and then recovered to 84% in 2023. Still 14.5 million infants did not receive an initial dose of DTP vaccine, pointing to a lack of access to immunization and other health services, and an additional 6.5 million are partially vaccinated.

Measles, because of its high transmissibility, acts as a "canary in the coalmine", quickly exposing any immunity gaps in the population, making an especially dangerous comeback. Still 22.2 million children missed their routine first dose of measles, far from 2019 levels with 19.3 million. Measles cases reached an estimated 10.3 million in 2023, a 20% increase compared to 2022.

In 2020, the World Health Assembly adopted the global strategy towards eliminating cervical cancer by vaccinating young people against the Human papillomavirus (HPV) that causes it and is also linked to head and neck, and anal cancers. In this strategy, the first of the 3 pillars require the introduction of the *HPV vaccine* in all countries and has set a target of reaching 90% coverage.

Childhood vaccination coverage has risen across Europe, with several countries managing to achieve the 95% coverage goal within the last ten years. This should be worthy of applause. However, coverage rates in many areas within the European region have a decreasing trend (Table 5). As a result, several European countries have experienced unprecedented outbreaks of vaccine-preventable diseases (VPDs), including measles outbreaks. The waning of public confidence in vaccination, geographical differences in accessibility, and rise of mis- and disinformation on vaccination are a cause of concern and a major challenge for public health experts in Europe[34].

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[32] https://www.unicef.org/press-releases/increases-vaccine-preventable-disease-outbreaks-threaten-years-progress-warn-who

[33] https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/gho-immunization-coverage-vaccine-preventable-diseases

[34] https://health.ec.europa.eu/vaccination/overview_en

Table 5. Immunization coverage and vaccine-preventable diseases in Europe, % [35]

Country	Hepatitis B among 1-year-olds		HPV among 9-14 years old girls		Diphtheria tetanus pertussis (DTP3) among 1-year-olds		Measles-containing-vaccine second-dose (MCV2)		Pneumoccocal conjugate vaccines (PCV3) among 1-year-olds		Polio (Pol3) immunization coverage among 1-year-olds	
	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022
Albania	97	97	74	15	97	97	93	93	85	87	97	98
Andorra	97	96	85	83	98	98	96	96	94	95	98	97
Armenia	94	96	41	15	94	93	96	94	94	93	94	93
Austria	84	84	71	58	84	84	94	94	-	-	84	84
Azerbaijan	83	83	-	-	83	83	93	91	82	83	91	88
Belgium	97	97	72	69	98	98	82	83	94	94	98	98
Bosnia and Herzegovina	77	78	5	-	73	75	63	60	-	-	75	75
Bulgaria	92	91	6	4	92	91	87	87	87	87	92	91
Croatia	92	90	55	55	92	92	90	90	90	90	93	92
Czech Republic	94	94	72	72	94	94	90	90	-	-	94	94
Cyprus	95	95	92	73	95	95	80	88	74	81	95	95
Denmark	-	-	80	78	97	97	93	94	97	96	97	98
Estonia	84	84	52	43	90	90	84	84	-	-	89	89
Finland	-	-	70	70	91	91	92	92	87	87	91	91
France	96	96	45	42	96	96	93	92	96	96	96	96
Germany	87	87	54	54	91	91	93	93	82	82	91	91
Georgia	93	85	40	34	88	85	86	78	86	79	88	85
Greece	96	96	-	-	99	99	83	83	96	96	99	99
Hungary	-	-	75	74	99	99	99	99	99	99	99	99
Iceland	-	-	84	85	92	92	89	80	92	84	92	92
Ireland	93	93	84	79	89	93	-	-	84	85	93	93
Italy	95	95	46	39	95	95	85	85	92	92	95	95
Latvia	97	95	71	55	98	95	92	86	95	87	98	95
Lithuania	89	90	43	63	90	90	86	87	82	81	90	90
Luxembourg	96	96	14	14	99	99	90	90	96	96	99	99
Malta	98	98	73	76	98	98	95	95	97	99	98	98
Moldova	88	90	44	45	87	88	93	93	85	79	88	88
Monaco	99	99	-	-	99	99	80	80	-	-	99	99
Montenegro	42	45	19	-	81	80	69	70	-	-	81	80
Netherlands	86	88	60	64	92	93	81	85	88	90	92	93
Norway	96	96	94	91	96	97	94	94	95	95	96	97
North Macedonia	86	84	40	47	86	84	88	89	56	56	86	84
Poland	90	90	-	-	94	94	86	86	88	88	85	85
Portugal	99	99	90	89	99	99	95	96	98	98	99	99
Romania	78	85	6	-	78	85	62	71	78	85	78	85
San Marino	91	91	52	50	91	92	79	85	83	80	91	92
Serbia	93	92	2	-	93	92	91	89	82	90	93	92
Slovakia	96	97	10	14	96	97	95	96	96	96	96	97

[35] https://www.who.int/data/gho/data/indicators

Slovenia	89	89	45	45	89	89	89	92	58	61	89	89
Spain	93	93	75	81	93	93	92	92	92	92	93	93
Sweden	94	94	88	88	94	94	92	91	94	94	94	94
Switzerland	80	76	70	71	95	96	91	94	89	89	95	96
UK and Northern Ireland	92	92	68	56	92	92	85	87	89	90	92	92
Ukraine	79	62	-	-	83	73	87	69	-	-	85	69

Concern regarding the declining trend of immunization coverage in their regions/countries is also expressed by the majority of survey respondents.

Survey results

"Over the past five years, Poland has experienced a significant decline in vaccination rates across various immunization programs. This trend has raised concerns among health officials about the potential resurgence of vaccine-preventable diseases. The rejection of mandatory immunizations, with the vaccine refusal rate doubling in five years, and thirteen-fold in a decade. Poland's National Institute of Public Health – National Research Institute (NIZP PZH – PIB) reports that throughout the last five years, the tally of refusals for mandatory vaccinations has nearly doubled, soaring from 48,600 refusals in 2019 to 87,300 in 2023. Vaccination coverage for measles has declined from 98% in 2010 to 91% in 2023. The percentage of children vaccinated against polio decreased from 96% in 2010 to 85% in 2023. In November 2024, the detection of the polio virus in Warsaw's sewage prompted health authorities to urge vaccinations, especially since only about 86% of Polish three-year-olds were vaccinated at that time, below the 95% threshold needed to prevent virus spread.

Influenza Vaccinations rates in Poland have remained consistently low. During the 2023-2024 flu season, only 5.5% of the population received the flu vaccine, despite nearly 14 million outpatient consultations for acute respiratory tract infections during this period.

Refusals of mandatory vaccinations have been monitored since 2003 by the NIZP PZH – PIB. Collected data pertains to individuals subject to vaccination in a given year, including children and adolescents up to the age of 19. Polish experts have developed a document outlining strategic recommendations for 2023-2027, with a focus on building trust in protective vaccinations. The authors of the report highlight that the increase in refusals for mandatory vaccinations can be attributed to various factors, including low public education regarding vaccinations, a lack of health literacy, inadequate doctor-patient communication, healthcare system organization issues, and the escalating activities of anti-vaccine movements. The percentage of staunch vaccine opponents (those with unwavering beliefs unaffected by argument) urgent need education and promotion of reliable, evidence-based knowledge. The percentage of such patients ranged from 20-40% in Poland and unfortunately, it is on the rise."

The Ombudsman for Children, Poland

#

"Over the past five years, vaccination rates in Italy have increased due to the introduction of new compulsory vaccinations and the campaign against COVID-19. In 2017, compulsory vaccination for 10 diseases was introduced, leading to an increase in vaccination rates, with coverage above 95 per cent in 2019, although some regions had lower rates. The vaccination campaign against COVID-19, which started in December 2020, resulted in the administration of more than 100 million doses by the end of 2021, including the paediatric population. Despite this progress, challenges such as regional disparities and vaccination hesitancy in some areas remain".

The National Authority for Children and Adolescents, Italy

#

"*Regardless of the full provision with vaccines and consumables, the 95% vaccination coverage target at the designated ages, as stipulated by the National Immunisation Program, was achieved nationwide in 2024 only for BCG vaccination (against tuberculosis), compared to other vaccines affected by the pandemic. The primary vaccination coverage of one-year-old children ranged between 77.6% (against rotavirus) and 87.6% (hepatitis B), 81.2% (against pertussis) and 82.1% (MMR – against measles, mumps, and rubella). A separate problem is the low level of vaccination in the Transnistrian region, where over the multiannual period 2020–2024, vaccination coverage indicators have remained below the objectives, except for tuberculosis vaccination, with minor fluctuations of slight increase or decrease".*

People's Advocate for child's rights, Republic of Moldova

#

"The vaccination rate is around 90% in the first year of child life but drops to even below 70% in the following years in some areas. Especially low is the first and second dosage of MMR vaccine."

Office of Ombudsman for Children, Republic of Srpska

#

"*It is noticed a gradual decrease in vaccination coverage over the last five years: 96% in 2020, and only 91.4% in 2024*".

The People's Advocate, Albania

#

"*Research conducted into pre-school vaccinations has found that there has been a downward trend in their uptake. In 2023, the Northern Ireland Audit Office found that of the 14 diseases which pre-school children are vaccinated against, there has been a decline in rates for 13 diseases. Moreover, many pre-school vaccination rates have now fallen below the WHO target rate of 95 per cent, including the single Meningococcal group C (Men C) vaccine (where rates fell below 95 per cent for the first time in 2017-18 and have remained below 95 per cent since), and the Rotavirus vaccination (since 2015-16)."*

Commissioner for Children and Young People, Northern Ireland

It is worth noting that a number of countries/regions have managed to maintain vaccination rates at a consistently high level. It is important to learn from and share the good practices and experiences of these countries, in order to increase vaccination rates in countries where the vaccination coverage indicators are below the recommended threshold.

"*All children and adolescents in Norway that are under the age of 20 are offered with vaccines against twelve different diseases: rotavirus disease, diphtheria, tetanus, whooping cough, poliomyelitis, Haemophilus influenzae type b (Hib) infection, hepatitis B, pneumococcal disease, measles, mumps, rubella, and human papillomavirus (HPV). The uptake of the vaccines in Norway is high and consistent, even when faced with challenge during the COVID-19 pandemic and the demanding work situation for health care providers. This proves the robustness of the National Immunization Program and its organizational structure for giving childhood vaccines, and high trust in childhood vaccine recommendations. While the WHO has announced challenged provision of childhood vaccines in many countries, the vaccination coverage in Norway has been equally high as in previous years. There is overall a low incidence of vaccine preventable diseases, which demonstrates a high effectiveness of the immunization program*."

The Ombudsman for Children, Norway

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"*The vaccination rate for children up to 2 years in Andalusia has remained stable and high during the last five years: over 96% of child population had received the complete protocol*."

The Ombudsman's Office, Andalusia/Spain

At the international level, the following barriers causing fluctuations in vaccination coverage rates are determined for the European countries[36]:

- Structural barriers (e.g., having to take time off work to get a child vaccinated)
- Delays in vaccine procurement
- Vaccine hesitancy (among the public and/or health care professionals)
- Spread of misinformation about vaccination
- The COVID-19 pandemic
- The Ukraine crisis.

Less than half of our respondents (48.1%) noted that they have no problems with vaccination in their jurisdiction, having a high rate of immunization in population. However, we note (Figure 10) that a large proportion of survey participants (40.7%) indicated fake news and anti-vax movements as a cause influencing vaccination. Many (18.5%) remain influenced by the cultural and/or religious values of the environment in which they live, or have personal reasons, such as fear or bad experiences of the parents with the vaccination process, which leads them to subsequently refuse vaccination for their children. These barriers to vaccination acceptance can only be overcome through a broad, well-organized process of information and awareness of the importance of immunization for children.

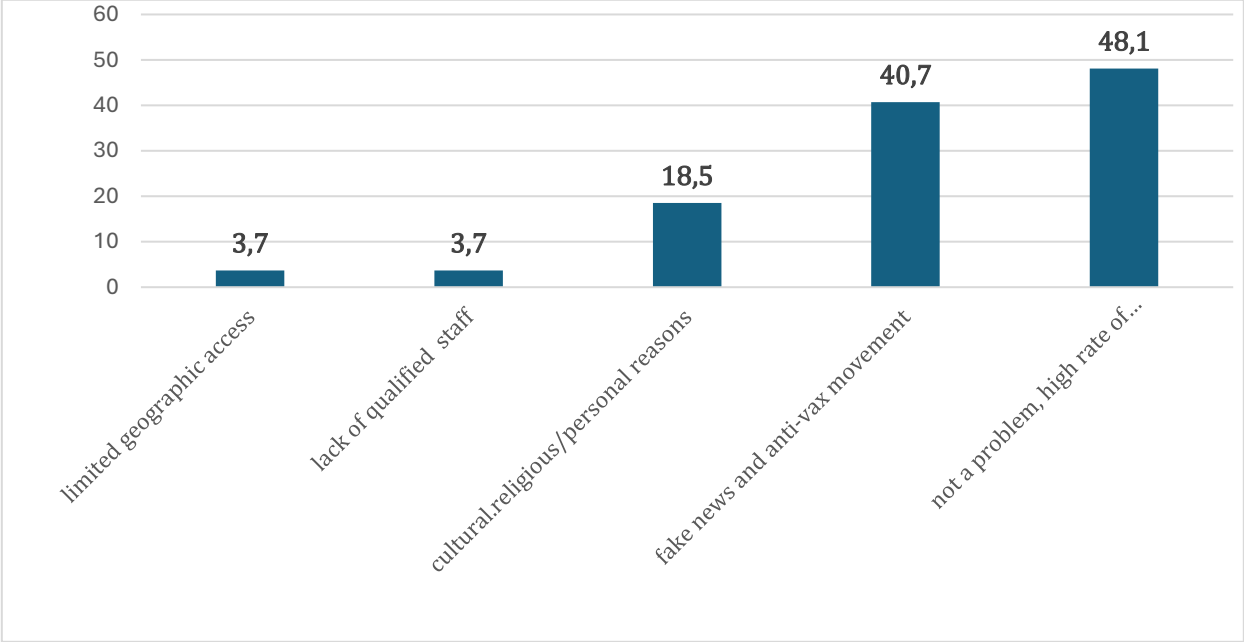

Figure 10. The main causes that are influencing the vaccination rates of children in 27 jurisdictions, %

"*Hesitation towards the MMR vaccine (Measles, Rubella, Mumps), due to the widespread fear that it can cause autism, a myth spread by non-scientific sources, which continues to influence some parents, despite strong opposition from the medical and scientific community. Fear that vaccines are harmful and "haram" - Some people from the Muslim community. The COVID-19 vaccination have had a negative impact on trust in vaccines."* The People's Advocate, Albania

[36] https://www.wfpha.org/improving-childhood-vaccination-coverage-rates-in-europe/

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"Fake news and anti-vax movement strongly influence the vaccination rates of children in Croatia. The creation of an anti-vaccination climate is certainly being contributed to by certain politicians who are opposed to mandatory vaccination about which they publicly express their views. There is also the problem of a strong negative influence on parents by opponents of conventional medicine and advocates of alternative approaches to child treatment and disease prevention, whose work and messages border on quackery. They operate mainly through closed groups on social networks where they dissuade parents from vaccination and the use of conventional medicine services."

The Ombudsman for Children, Republic of Croatia

In all jurisdictions included in the study, free and open access to vaccination is ensured. Mandatory vaccination for school attendance is an accepted condition in only a third (33.3%) of the jurisdictions included in the survey. Extensive and frequent information campaigns are mentioned by 74.1% of respondents. In many jurisdictions the centralized reminder/recall method is practiced (70.4%), as well as the community-based and parent-focused interventions (55.6%). Informational vaccine websites with interactive social media components are implemented by almost two-thirds (63%) of respondent jurisdictions (Figure 11).

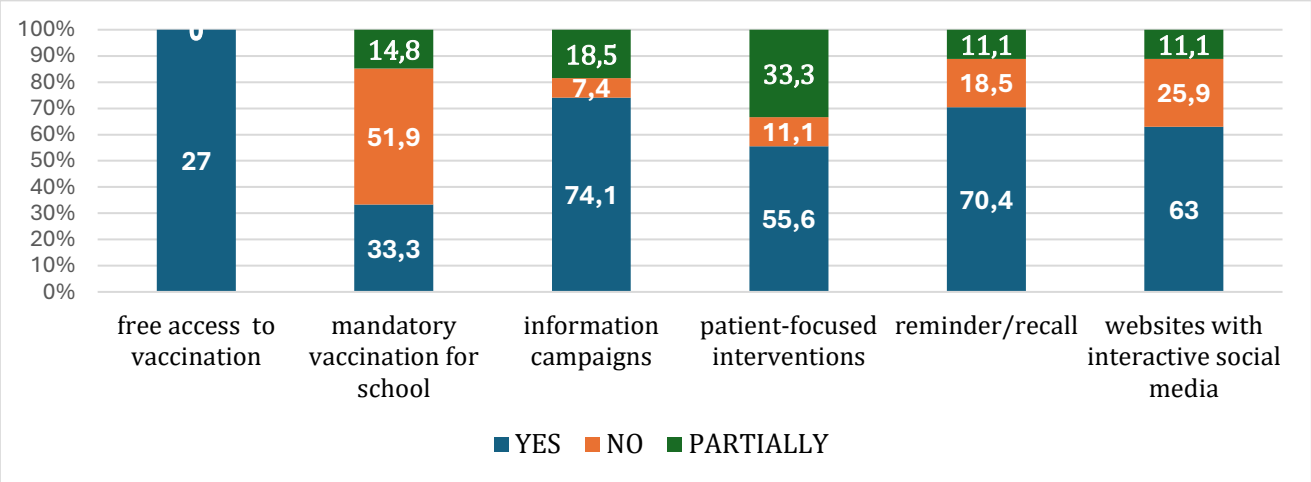

Figure 11. Interventions developed in 27 jurisdictions to maintain high vaccination rate, %

Policy level approach

The decreasing trend of immunization process must initiate the strengthening of the efforts to combat barriers around vaccination uptake, as robust and resilient vaccination systems are crucial to protecting the population from preventable illnesses and deaths due to VPDs, as well as ensuring recovery from any future crises. Countries are called to tackle vaccine hesitancy and increase the uptake of vaccination by:

- Facilitate access to vaccination (increase range of providers to administer vaccination; enable providers to administer vaccines at childcare facilities; outside of regular work hours).
- Ensure sufficient infrastructure and health worker capacity.
- Increase use of digital technologies (improve real-time data collection and disease surveillance systems, automated vaccination reminders, etc.)

- Improve education and awareness regarding the value of vaccination (public awareness and communication campaigns, public health education programs)

2.4. Road safety

Public health problem

Every two minutes a child is prematurely lost on the roads of this world. Many more are injured, often severely. Worldwide nearly 220,000 children and adolescents aged 0–19 years die annually due to road traffic injuries. That is more than 600 preventable road deaths among children and young people each day. In addition to a high mortality burden, road traffic collisions cause a significant number of children to be disabled, sometimes for life. Years lived with disability (YLD) is a measure of the years of healthy life that are lost due to disability. Road traffic injuries are the tenth leading cause of YLDs among children aged 15–19 years and the thirteenth overall cause of YLDs for children aged 0–19 years [37].

In addition, rates of road traffic death among children are typically 3 times higher in low- and middle-income countries than in high-income countries. More than half of all road traffic deaths are among vulnerable road users, including pedestrians, cyclists and motorcyclists[38].

Of the 27 regional offices included in the survey, only 20 offices were able to provide data on the number of children killed in road accidents in their regions. Thus, about **500 children die** annually due to injuries caused by road accidents in 20 countries/ regions included in the survey (table 6).

Table 6. Number of road traffic deaths among children in 20 jurisdictions

Year	2019	2020	2021	2022	2023
Total children killed in 20 ENOC countries/ regions	504	478	498	501	501

These traumatic events cause immeasurable suffering and grief, and at times economic hardship for families and friends. In addition, they cost societies precious resources, diverting these from other pressing health and development challenges. Many of the children who are victims of this man-made calamity are poor. Attempts to address road safety for children are, therefore, inextricably linked to notions of social justice.

Road safety is a child's rights issue, linked to health and survival, education, protection and participation rights and a global development challenge with strong impacts on health, wellbeing and economic growth. Children have a right to use a road environment free of injuries and free of pollution. Core commitments to safe and healthy communities, including safe roads, is needed. This will support reaching the targets of the Sustainable Development Goals and the Global Plan for the UN Decade of Action for Road Safety to reduce road deaths and injuries by at least 50 per cent in the period 2021–2030 (A/RES/74/299).

[37] UNICEF. Technical Guidance for CHILD AND ADOLESCENT ROAD SAFETY. https://www.unicef.org/media/130721/file/UNICEF_Child_and_Adolescent_Road_Safety_Technical_Guidance_2022.pdf

[38]. World Health Organization. Fact sheets. Road traffic injuries. https://www.who.int/news-room/fact-sheets/detail/road-traffic-injuries

From the answers of the 27 respondents of the survey we can see that in many jurisdictions the problem of road safety is not addressed to the necessary level. Only in 13 jurisdictions (48.2%) is there are well-planned and financed strategic actions, with strict monitoring of implementation. In 8 jurisdictions (29.6%) the actions are taken occasionally, sporadic, with insufficient funding. It is alarming that in 4 jurisdictions (14.8%) there are no strategic provisions and no actions in this area, and 2 responders (7.4%) recognized that in their jurisdictions there are some provisions in the policy documents, but no measures are taken in this regard (Figure 12).

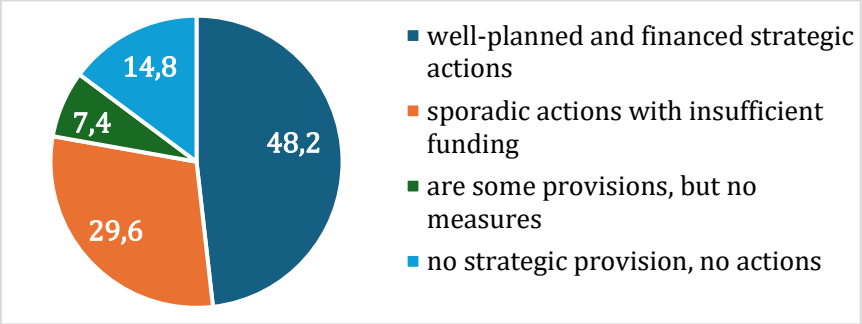

Figure 12. Strategies to prevent death or injury of children as a result of road accidents, 27 jurisdictions. %.

"Poland implements several strategic programs and policies aimed at preventing child injuries and fatalities. These initiatives include both national-level plans and local prevention activities.
1. National Program for Child Accident Prevention (Coordinated by institutions including the Ministry of Health, Ministry of Education and Science, Ministry of Infrastructure, and National Police. Includes campaigns to raise awareness among parents, teachers, and children about road safety, home safety, drowning prevention, and traffic safety)
2. National Road Safety Program specifically addresses child safety through: Promotion of child restraints (car seats, seat belts). Educational campaigns on safe pedestrian behavior. Improvement of infrastructure around schools and playgrounds (speed bumps, crossings, speed limits)."

The Ombudsman for Children, Poland

Policy level approach

Governments must take action to address road safety in a holistic manner. This requires involvement from multiple sectors such as transport, police, health and education, as well as the private sector and civil society organizations. It requires actions that address the safety of roads, vehicles and all road users[39]. It is extremely important to address the combination of factors, including poorly designed roads, limited transportation options, inappropriate vehicle speeds and other risky behaviors, as well as a lack of road infrastructure plans and policies.

The states should prepare child responsive urban planning, that would combine road safety with air quality and fair mobility for all children. When children are able to move and play freely in their local neighborhoods, they reap significant health, physical, social and mental development benefits. Effective interventions include designing safer infrastructure and incorporating road safety features into land-use and transport planning, improving the safety features of vehicles; enhancing post-crash care for victims

[39] World Health Organization. Ten strategies for keeping children safe on the road. https://www.who.int/publications/i/item/ten-strategies-for-keeping-children-safe-on-the-road

of road traffic crashes; setting and enforcing laws relating to key risks, and raising public awareness. Wider social, economic and environmental benefits of these transformations include reduced health system costs from fewer road traffic injuries and disabilities, less traffic congestion, through lower air and noise pollution with the use of new technologies, increased walking and bicycling to improve health and reduce non-communicable diseases and improved overall safer and child-friendly communities that contribute to economic growth.

2.5. Drowning

Public health problem

Drowning is a major yet often neglected public health problem. There are around 300 000 annual drowning deaths worldwide[40]. Drowning is the fourth leading cause of death for children aged 1–4 years and the third leading cause of death for children aged 5–14 years. The most vulnerable victims of drowning are children from low and middle-income countries. Thus, the World Health Organization (WHO) has classified drowning as a major public health problem[2].

Though drowning is a serious public health issue, it has not received the same attention as other significant causes of infant death. Immaturity and defeatism may be partly responsible for the failure of public awareness campaigns. Drowning has become a leading cause of children's death due to this carelessness. However, the overall rate of drowning remains consistent. It is no secret that drowning deaths are sporadic. Structure and culture have a significant role in this.

The Global status report on drowning prevention shows that drowning deaths rates have dropped significantly in recent years. Since 2000 the global drowning death rate has fallen by 38%, from 6.1 to 3.8 per 100 000 population. Despite this progress, drowning remains an urgent and often overlooked global health issue and drowning deaths remain a preventable public health crisis.

Survey results

The study found that only 17 of the 27 countries/ regions included in the survey keep separate records of child drowning. Between 2019 and 2023, **689 children** died from drowning in these regions - deaths that could certainly have been avoided.

Table 7. Number of recorded child drownings in the region (17 jurisdictions).

Year	2019	2020	2021	2022	2023
Child drownings recorded in 17 ENOC countries/ regions	141	144	166	122	116

Measures to prevent childhood drowning in unsupervised pools are not a priority for strategies in more than half of the jurisdictions included in the study (Figure 13).

[40] World Health Organization. https://www.who.int/news-room/fact-sheets/detail/drowning

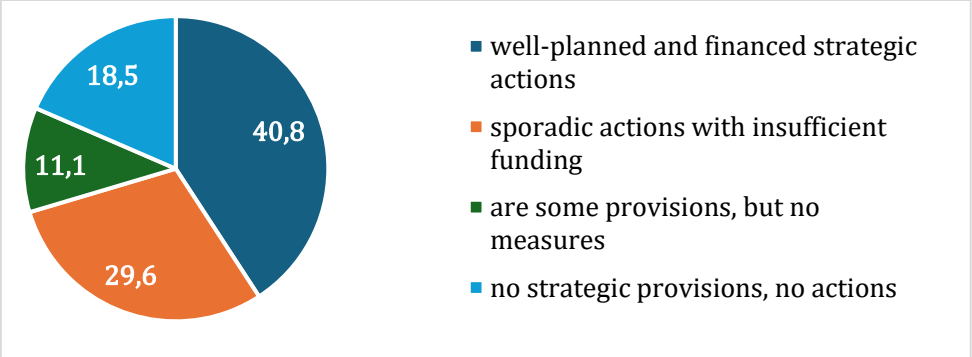

Figure 13. Strategies to prevent death or injury of children as a result of drowning, 27 jurisdictions. %.

In the answers of some respondents, we identified positive practices that could serve as a model to be implemented in other regions/countries.

"In Lithuania, the National physical activity program, designed to teach children to swim and develop safe behavior skills in and around water was adopted in 2009, which aims to: teach participants safe behavior in and around water; teach participants to swim, etc. Swimming is a great form of physical activity. It is important for the socialization of children and young people. Teaching swimming skills is closely linked to the development of personal hygiene. Swimming is a vital skill. Children are classified as a higher risk group (they are curious, prone to taking risks, and often unable to assess the situation), so they must be taught to behave safely near and in the water. "

The Ombudsperson for Children's Rights, Lithuania

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"National and regional campaigns and education programs aimed at raising awareness about water safety, especially during summer months. Promotion of safe behavior in recreational areas, mandatory lifeguard presence at public beaches, and educational initiatives in schools."

The Ombudsman for Children, Poland

Policy level approach

Resolutions endorsed by the United Nations General Assembly and the World Health Assembly provide a roadmap for global drowning prevention efforts. Governments must reinforce proven prevention measures and prioritize drowning prevention and its integration with other public health agendas. There are many actions to prevent drowning. Covering wells, using doorway barriers and playpens, fencing swimming pools and otherwise controlling access to water hazards greatly reduces water hazard exposure and risk.

In April 2021, the UN General Assembly adopted the first Resolution on drowning prevention, which highlighted links to sustainable development, social equity, urban health, climate change, disaster risk reduction, and child health and well-being. The Resolution called to coordinate multisectoral drowning prevention efforts within the UN system and announced 25 July as *World Drowning Prevention Day.*

Community-based, supervised childcare for pre-school children can reduce drowning risk and has other proven health benefits. Teaching school-age children basic swimming, water safety and safe rescue skills is another approach. But these efforts must be undertaken with an emphasis on safety, and overall risk management that includes a safety-tested curricula, a safe training area, student-instructor ratios established for safety.

2.6. Substance abuse

Public health problem

Substance (drug) abuse or misuse is the use of a drug in amounts or by methods that are harmful to the individual or others. Substance abuse is the abuse of one of the 10 classes of drugs which include cannabis, alcohol, caffeine, hallucinogens, hypnotics, opioids, anxiolytics, inhalants, tobacco, and sedatives as well as other, possibly unknown, substances[41].

In many countries, alcohol and tobacco, are legally available and widely used. The consumption of cannabis, cocaine and opiates is generally illicit. Some substances, such as tranquillizers, are often legally available through medical prescription but may be used illicitly in order to produce psychoactive effects. The use of various illicit drugs is widespread in many countries.

Adolescence is a critical developmental phase involving significant physical, cognitive, emotional, social, and behavioral changes. All substance use, even experimental use, puts adolescents at risk of short-term problems, such as motor vehicle crashes, fights, unwanted sexual activity, and overdose - receiving too much of a substance (medication, illicit drug, alcohol), at once, that could be life threatening.

Adolescents who use substances have higher rates of sexually transmitted infections (STIs), HIV and are more likely to develop a substance use disorder. The neurobiological alterations underlying these complex developmental processes may predispose adolescents to develop substance use disorders, and to experience potentially serious and long-lasting substance-related adverse consequences such as mental health disorders, underachievement in school, poor functioning in adulthood, and higher rates of addiction.

Drug use is by no means the prerogative of the young alone. Nevertheless, rates of drug abuse are higher among adolescents and youth than among adults. More and more young people are using a greater variety of psychoactive substances and at younger ages than ever before. Surveys on drug use among the general population show that the extent of drug use among young people remains higher than that among older people, although there are some exceptions associated with the traditional use of drugs such as opium or khat. Most research suggests that early (12–14 years old) to late (15–17 years old) adolescence is a critical risk period for the initiation of substance use and that substance use may peak among young people aged 18–25 years. Data for the 28 States members of the European Union, plus Norway and Turkey, show that the lifetime use in those countries of amphetamines and "ecstasy" is between two and three times higher among those aged under 35 than among older people. Past-month use of most drugs is up to seven times higher among young people. However, current use of "ecstasy" is nearly 20 times higher among people aged 15–24 than among those aged 45–54. By contrast, the rates of lifetime prevalence of cocaine in Europe among those aged 15–24 and those aged 45–54 are comparable, while lifetime use of cannabis is much higher among those aged under 35.[42]

Alcohol consumption

Alcohol is the most commonly used substance among adolescents, with 64% of 18-year-olds endorsing lifetime alcohol use, followed by marijuana (45%) and cigarette use (31%). A survey conducted on adolescents in the United States reported that in 2023 by 12th grade, 46% of adolescents have tried

[41] *Diagnostic and statistical manual of mental disorders: DSM-5* (Fifth ed.). American Psychiatric Association. 2013. p. 490. ISBN 978-0-89042-557-2.

[42] UNODC. DRUGS AND AGE Drugs and associated issues among young people and older people. Available at https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_4_YOUTH.pdf

alcohol in the past year, 33% have been drunk in the past year, 24.3% have consumed alcohol in the past 30 days, and 10% have consumed more than 5 drinks in a row in the prior 2 weeks. Because adolescents often drink alcohol directly from the bottle or pour their own drinks, a drink for them may be larger than a "standard" drink for adults..[43] According to UNICEF's 'The State of the World's Children' report, globally, 36% of boys and 17% of girls aged 15 to 19 have had at least one alcoholic beverage in the last year (2020).

Some adolescents who try alcohol develop an alcohol use disorder. Risk factors for developing a disorder include starting drinking at a young age and genetics. Adolescents who have a family member with alcohol use disorder should be made aware of their increased risk of developing a substance use disorder and should receive support from a health care professional.

Binges put adolescents at risk of accidents, injuries, unprotected or unwanted sexual activity, and other unfortunate situations. For these reasons, adolescents should be discouraged from drinking. The *WHO-UNICEF-Lancet Commission on the future of the world's children*[44] highlighted in 2020 the need to address alcohol harm and to use alcohol policy solutions to protect children from predatory commercial behavior of the alcohol industry that is encouraging harmful and addictive activities that are extremely deleterious to young people's health.

Tobacco

The majority of adults who smoke cigarettes began smoking during adolescence. Adolescents who try cigarettes at age 13 or before are more likely than other adolescents to continue to smoke tobacco as adults.

Combustible tobacco products are products that need to be burned so they can be consumed, for example, conventional cigarettes, cigars, and hookahs. Rates of combustible tobacco use among adolescents fell dramatically in the 1990s and 2000s and continue to decline. The *Monitoring the Future Survey* reported that in 2023, approximately 2.9% of 12th graders reported current cigarette use (smoked in the previous 30 days), which was down from 28.3% in 1991. Only approximately 0.7% of 12th graders reported smoking every day[45].

Adolescents may also use tobacco products in other forms. Approximately 2.5% of 12th graders are current users of smokeless tobacco. Smokeless tobacco can be chewed (chewing tobacco), placed between the lower lip and gum (dipping tobacco, or dip), or inhaled into the nose (snuff). Electronic cigarettes (e-cigarettes, e-cigs, vapes) are battery-operated devices that use heat to turn a liquid into a vapor that can be inhaled. These liquids typically contain nicotine, which is the active ingredient in tobacco, or tetrahydrocannabinol (THC), which is the active ingredient in cannabis. E-cigarettes initially entered the market as alternatives to smoking for adult smokers, and initial models were not used much by adolescents. They have since morphed into "vapes," which are highly attractive to, and have become increasingly popular among adolescents over the past several years, especially among adolescents of middle and upper social and economic status. E-cigarettes cause different negative health effects than smoking tobacco. However, like regular cigarettes, chemicals contained in e-cigarettes can cause lung injuries. Lung injuries can be sudden, severe, or long-lasting and, when most severe, lethal. In addition,

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[43] Gray KM, Squeglia LM. Research Review: What have we learned about adolescent substance use? J Child Psychol Psychiatry. 2018 Jun;59(6):618-627. doi: 10.1111/jcpp.12783.

[44] https://www.thelancet.com/commissions-do/future-child

[45] Bagley S. Substance Use in Adolescents. https://www.msdmanuals.com/home/children-s-health-issues/health-care-issues-in-adolescents/substance-use-in-adolescents

these products can deliver very high concentrations of nicotine and THC. THC and nicotine are highly addictive, and toxicity is possible.

Survey results

Only in the less than half of the responding jurisdictions (48.1%) are organized well-planned and financed strategic actions there, with strict monitoring of implementation regarding addiction with and without substances. In the rest, sporadic actions are organized, without adequate funding (33.4%), or (18.5%) such actions remain only on paper, in the policy documents, without being implemented (Figure 14).

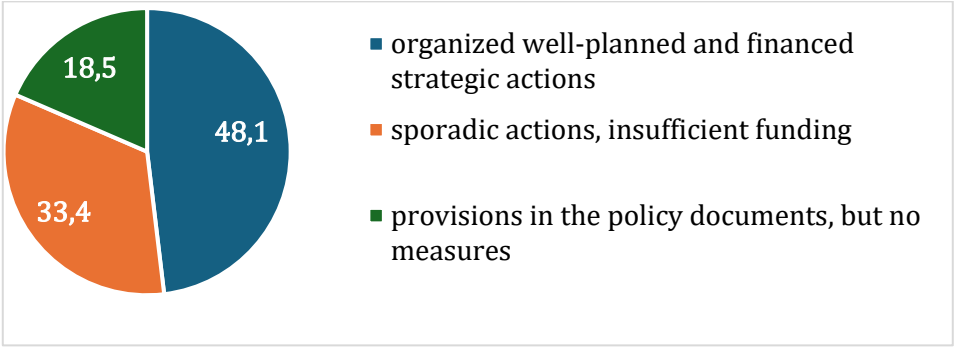

Figure 14. Strategies to prevent death or injury of children as a result of addiction with and without substances, 27 jurisdictions, %.

Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improve physical, mental, and social wellbeing; and offer low barrier options for accessing health care services, including substance use and mental health disorder treatment. In the jurisdictions included in the survey, different approaches to harm reduction are determined. Only in 9 jurisdictions are developed general plan addressing addiction with and without substances, 4 jurisdictions reported presence of the general plan only addressing addiction with substances. In several jurisdictions (12), the problem-based approach prevails, with targeted specific programs being implemented for different problems to address: tobacco, alcohol, illegal substances, games, screens, etc. One jurisdiction reported a complete lack of such plans or strategies (Figure 15).

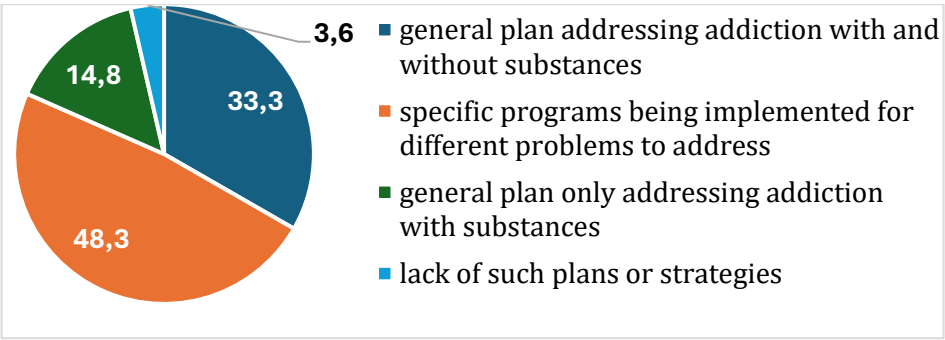

Figure 15. Harm reduction strategies to prevent addictions with and without substances in 27 jurisdictions, %.

Respondents provided us with examples of good practices implemented at the level of the jurisdictions they represent. Multiple programs and strategies implemented at the jurisdictional level, focused on harm reduction, were presented and described.

"*The Ministry of Education and Sport in collaboration with the Ministry of Health and Social Protection and local State Police have implemented several programs aimed at educating young people about the consequences of using narcotic substances. In cases where it is found that a student is using drugs (this is confidential data), the school cooperates with parents, social protection institutions health institutions and rehabilitation centers to provide psychological and medical assistance."*

The People's Advocate, Albania

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"*In Poland, several harm reduction strategies have been implemented to address substance use issues, such as: Needle and Syringe Exchange Programs; Comprehensive Harm Reduction Policies; School-Based Prevention Programs; "ARS, czyli jak dbać o miłość?" Program targeting secondary school students to reduce the consumption of alcohol, tobacco, and other psychoactive substances; "Unplugged" Program addressing students aged 12-14 to prevent the initiation of psychoactive substance use; "Too Good For Drugs" Program on changing attitudes and intentions regarding the use of tobacco, alcohol, and drugs among youth."*

The Ombudsman for Children, Poland

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"*Agenzija Sedqa places a strong emphasis on primary prevention through structured school programs tailored to different age groups. These include T.F.A.L.3 for children aged 7–8, T.F.A.L.5 for those aged 9–10, and Teen Outside the Box for 11–12-year-olds. Additionally, the BASH! program is implemented across post-secondary and tertiary institutions through three interactive exhibitions. Beyond school-based initiatives, community sessions play a crucial role in reaching minors who we may not have reached through education settings. However, for minors already using substances, it becomes essential to shift towards harm reduction strategies. These youths are often encountered in post-secondary and tertiary settings, where we provide guidance on safer use, particularly concerning cannabis. While we emphasize that the safest choice is not to use substances at all, we also provide practical advice to minimize risks for those who choose to do so. For example, we collaborate with local taxi services to offer discounted rides, promoting safer alternatives to driving under the influence.*

Our harm reduction approach is centered on a non-judgmental and supportive attitude, ensuring that individuals feel safe seeking help. This philosophy extends to the Addictions Community Team, where social workers provide additional support sessions to young people in need.

One of our targeted harm reduction interventions is the programme implemented within Learning Support Centres, which cater to students facing behavioral and socio-economic challenges. These settings often include youths who are already engaged in substance use. To address this, we have developed a three-session program titled "Hurt by Others, Healed Through Others", in collaboration with Komunita Santa Maria. In this program, residents from the rehabilitation center join students in discussions and hands-on activities, providing real-life testimonials and empowerment tools to help them reflect on their choices and their potential impact."

Office of the Commissioner for Children, Malta

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"In Flanders, VAD ("Vlaams expertisecentrum Alcohol en andere Drugs", Flemish expertise centre Alcohol and other drugs) is the official partner organisation from the Flemish government for alcohol, drugs, psychoactive medication, gambling and gaming, from a welfare and health perspective. They collect and process information, develop prevention methods that we then implement and evaluate,

and organise training. They target both the general public and professionals. They also offer the "Druglijn", a hotline every citizen can call with questions about addiction."

Office of the Children's Rights Commissioner, Flanders/Belgium

However, several jurisdictions have mentioned various problems and challenges they face in carrying out reduction actions.

"*On August 8, 2024, the Ombudsman's Office of Latvia published a report titled "On Providing Assistance to Children Who Use Addictive Substances." The report highlights that Latvia lacks an effective system for treating and rehabilitating children and adolescents suffering from addiction. The current legal framework allows minors to refuse treatment, which can lead to situations where children choose to continue using addictive substances rather than receive the necessary help. The report includes 20 recommendations to the Ministry of Health, including the need to develop harm reduction strategies to prevent addictions with and without substances. "*

The Ombudsman's Office, Latvia

Policy level approach

Drug use among young people differs from country to country and depends on the social and economic circumstances of those involved. Youth policies addressing substance abuse aim to prevent and reduce misuse and addiction by promoting healthy behaviors, educating youth about the risks, and providing support services. These policies often encompass community-based prevention programs, school-based interventions, and targeted treatments for those who have developed a substance use disorder. Drug use and addiction prevention programs should mandatory involve families, schools, communities, and the media.

It is extremely important to enhance the capacity of relevant Governmental and Non-Governmental Organizations to develop, implement, and evaluate a comprehensive evidence-based program on prevention of substance use among adolescents; to ensure more access to comprehensive substance use preventive services, life and social skills training, education, counselling, screening and interventions.

2.7. Mental health issues – behavioral addictions and children's rest

Public health problem

Behavioral addictions

In recent times, modern mental health disorders such as behavioral addictions (BAs) have slowly yet surely gained attention as emerging public mental health problems. Behavioral addictions are defined as, "an intense desire to repeat some action that is pleasurable or perceived to improve wellbeing or capable of alleviating some personal distress." What classifies some behaviors as addictive is the difficulty those affected have with stopping or reducing their participation in it[46]. Individuals can form behavioral addictions similar to a dependence on drugs and alcohol to combat anxiety, depression, or other mental health disorders. Increases in drug and alcohol use have signaled that many people are abusing harmful chemicals; however, some don't factor in non-substance addictions like food addiction, phone addiction, social media addiction, or video game addiction, which often manifest as a behavioral addiction due to

[46] https://www.addictioncenter.com/behavioral-addictions/

underlying mental health challenges. Those who become addicted to specific activities seek out feelings of comfort, happiness, and chemical releases (dopamine and serotonin) or can form behavioral addictions to escape reality or painful emotions. Some of the most common types of behavioral addictions are: gambling addiction, internet addiction, shopping addiction, screen addiction etc. Because behavioral addictions impact the part of the brain responsible for rewards, individuals can experience similar effects one would feel if they were abusing a substance. This can translate to troubled relationships, challenges with impulse control, obsessions, distractions, and financial challenges. Treatment methods used for substance abuse can be helpful in treating behavioral addictions.

The global prevalence of BAs is 11.1%, the highest for smartphone addiction (30.7%), followed by food addiction (21%) and others. Youths are particularly vulnerable due to the appeal of digital platforms and limited self-regulation. Individuals with BAs struggle with emotional and behavioral regulation, impaired relationships, health issues, and reduced performance. Over the past decade, the prevalence of BAs has risen significantly, posing a substantial mental health challenge. Recognition of problems such as gambling as a mental disorder already existed in the International Classification of Diseases (ICD) under the "gambling disorder" rubric. Recently, acknowledging the problem of internet usage and the addictive nature of internet games (video games), ICD 11 have also added "computer gaming disorder" as a new diagnostic category. Alarming statistics and effects pose a major public mental health concern for health professionals, policymakers, and social institutions[47].

Children's rest and sleep

A frequently discussed topic regarding children's mental health is their rest and sleep. Quality of sleep in children refers to the duration, quantity, and timing of sleep, with a focus on sound, restful sleep with minimal disruptions. Adequate and quality sleep is crucial for children's physical and mental well-being, supporting growth, learning, and emotional development. Several factors affect sleep quality in children including genetics, sleep habits, medical problems, parents/caregiver factors, screen time and the child's environment[48].

Survey results

Behavioral addictions remain largely unregulated and under-researched and this is also evident from the responses of many survey participants. Many respondents mention that occasional, sporadic actions or even no concrete measures are dedicated to this area. From Figure 10 we can see that only in a third of the responding jurisdictions (33.3%) there are strategic approaches and plans addressing addiction without substances.

The issue of monitoring sleep quality in children is approached differently in the responding jurisdictions. Programs or plans to promote good quality of rest and sleep among children exist only in 40.7% of the jurisdictions involved in survey (Figure 16).

[47] Das, S., Pandey, M. K.. Behavioral Addictions: An Emerging Public Mental Health Crisis. *Indian Journal of Social Psychiatry* 39(3):p 230-235, Jul–Sep 2023. | DOI: 10.4103/ijsp.ijsp_227_23

[48] Fadzil A. Factors Affecting the Quality of Sleep in Children. Children (Basel). 2021 Feb 9;8(2):122. doi: 10.3390/children8020122.

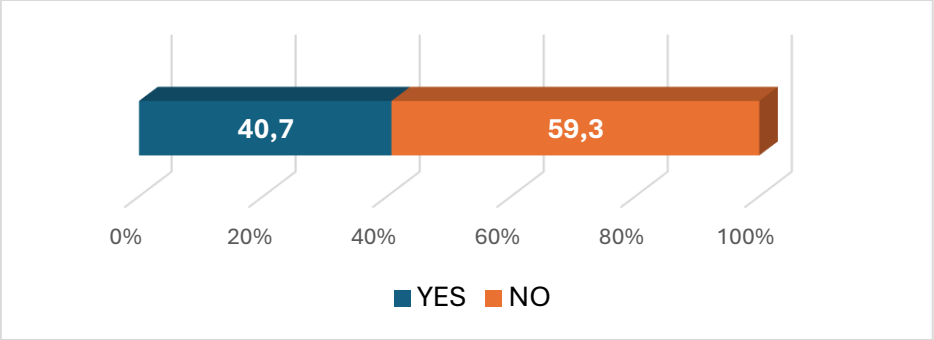

Figure 16. Programs/plans to promote good quality of rest and sleep among children, 27 jurisdictions, %.

It is interesting to see the good practices presented by different jurisdictions for promoting proper sleep hygiene in children.

"In Italy, there are numerous programmes and initiatives aimed at raising awareness and educating both minors and their families on the importance of good sleep. These programmes are supported by school initiatives, scientific guidelines and local interventions that also address sleep-related disorders and problems resulting from excessive use of technology".

The National Authority for Children and Adolescents, Italy

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"Sweden National Child Health Program aims to promote children's health and development through health surveillance, health promotion and parenting support. Part of this work includes providing knowledge about children's sleep and sleep hygiene. Child health services offer parent groups to discuss everyday life and sleep. The aim is to help parents find a balance between sleep and wakefulness for both themselves and their children, as well as to reduce stress around the child's bedtime and nighttime awakenings. School health services play an important role in providing information about the effects of insufficient or poor sleep and the importance of regular sleep habits. They can also promote good sleep by highlighting the importance of physical activity and outdoor activities at school. Projects such as "Sleep, health and well-being in children and adolescents" aim to evaluate the impact of school-based interventions to promote teenagers' sleep. Such programs can provide valuable insights and methods to improve sleep quality in adolescents."

Office of the Ombudsman for Children, Sweden

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"Recommendations of the Catalan Public Health to promote good quality and sleep of children and adolescents".

The Ombudsman's Office, Catalonia/Spain

However, some jurisdictions have shared their concerns regarding this topic, recognizing that the measures taken are not sufficient to achieve the desired results.

"Health promotion is identified as being very deficient from this point of view. It involves different sectors and ministries, but without alignment of the related policies. There are one-off actions (such as the workshops of the medico-social league, offered in schools, on the themes of nutrition, emotional life, hygiene, well-being, sleep) or initiatives covering a field of activity (such as the programme 'Gesond iessen mei bewegen' which has covered the field of nutrition and physical activity since 2006), but without a common dynamic around the concept of overall health (physical, mental and social)".

The Ombudsman for Children and Adolescents, Luxemburg

Policy level approach

In the context of children and adolescents in Europe, the rise in screen time, online gaming, and social media engagement has made addressing behavioral addictions particularly urgent. A policy-level approach requires collaboration across sectors, including healthcare, education, technology, law, and social services. The WHO recognizes the problem of BAs and emphasizes that more research is required to get a true estimate of the problem, including the development of reliable assessment tools to formulate interventional strategies[49].

It is important to incorporate behavioral addictions into national health strategies and public health agendas, recognizing the harmful impact on young people's mental health and social development.

Behavioral addictions should be defined clearly within the context of mental health disorders (similar to how substance abuse is handled) so that they can be addressed in clinical settings and via public health policies.

Early prevention programs should be introduced within the school curriculum to raise awareness about the risks of behavioral addictions and promote healthy coping mechanisms. Programs should focus on media literacy, helping children and adolescents understand the psychological and social impacts of overuse of digital devices and online platforms.

Encouraging physical activities, in-person socialization, and creative hobbies as alternatives among children. School-based interventions should be implemented that promote mental health literacy, teaching students how to identify addictive behaviors and where to seek help.

Age-appropriate education should be provided on the risks of online gaming, excessive screen time, and social media use, along with resources for digital well-being.

Rest and sleep are mandatory parts of the necessary conditions for the correct and healthy development of children. Given the critical importance of sleep, a comprehensive policy approach is needed to support healthy sleep habits and ensure that children in Europe can access the rest they need for optimal development. This approach should involve a combination of education, public health campaigns, regulations, and support for families and schools to create environments conducive to good sleep. For this reason, the states should ensure information and awareness among the population about this subject, provide continuous professional development on safe sleeping, but also develop a broad regulatory framework, policies and practices on safe sleeping for creating healthy conditions for children in educational institutions[50].

2.8. Healthy and safe environment

Public health problem

Every child has the right to a safe and healthy environment, which includes healthy air, water, and food, and protection from environmental hazards**.** The United Nations Secretary-General's 2020 report (A/75/307) on the Status of the Convention on the Rights of the Child (CRC) highlights climate change and environmental degradation as a significant challenge in implementing the CRC. Climate change threatens children's lives, destroys critical infrastructure, affects their chances of survival and is an

[49] WHO. Addictive Behavior https://www.who.int/health-topics/addictive-behaviour#tab=tab_1

[50] WHO Standards for healthy eating, physical activity, sedentary behaviour and sleep in early childhood education and care settings: a toolkit. 2021. https://iris.who.int/bitstream/handle/10665/345926/9789240032255-eng.pdf

obstacle to the enjoyment and realization of their rights. Moreover, the increasing incidences of cancer, diabetes, neurodevelopmental disorders and asthma globally have accompanied the rapid rise in air pollution, e-waste and harmful chemicals in everyday products, among other hazards. The World Health Organization (WHO) estimates that 26 per cent of deaths in children under 5 years of age can be prevented by addressing environmental risks. Globally, the increasing incidence of cancer, diabetes, neurodevelopmental disorders and asthma have accompanied the rapid rise in air pollution, e-waste and other harmful chemicals in food, water and everyday products. Disturbingly, 1.8 billion children under the age of 15 years breathe toxic air that puts their health and development at serious risk. Around one in three children – up to 800 million globally – have blood lead levels at or above 5 micrograms per deciliter blood (µg/dL). Childhood lead poisoning can lead to lower IQ, attention deficits, poor academic performance and is linked to violent behavior later in life[51].

Survey results

Although a majority of respondents (70.7%) confirmed that environmental policies are considered in child health policies or programs in their jurisdictions, but it is alarming that, practically, one in four respondents (29.6%) deny this fact.

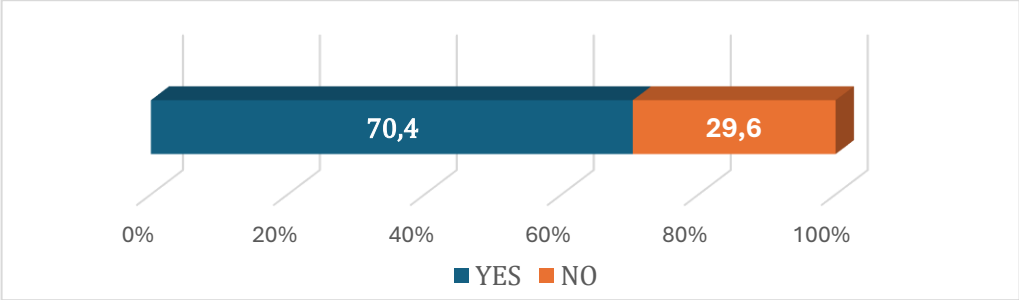

Figure 17. The presence of environmental factors (e.g., air quality, water pollution, climate change) in child health policies/programs in 27 jurisdictions, %.

Respondents mentioned many local/national level documents in support of this topic, describing many relevant and innovative measures and actions.

> "*The education system in our country is paying increasing attention to the integration of environmental factors into educational policies, teaching programs and school curricula by evaluating the importance of the impact of air quality, water pollution and climate change on the health and well-being of students. In 2023, the Ministry of Education and Sports (MES) became part of the global initiative of the "Greening Education Partnership (GEP)" which aims to develop a coordinated and comprehensive interaction that will prepare every student to acquire the knowledge, skills, values and attitudes to address climate change and promote sustainable development through the following four pillars: a) Green schools; b) Green curriculums, aiming to integrate climate change into school curricula and teaching practices at all levels of education; c) Green teacher training and education system capacities, which aims to strengthen policies related to the professional development of teachers for green teaching and learning; d) Green communities, which aims to integrate climate education into lifelong learning, especially through community learning centers*."
>
> The People's Advocate, Albania

[51] UNICEF. Healthy Environments for healthy Children. Global Programme Framework. 2021. https://www.unicef.org/media/91216/file/Healthy-Environments-for-Healthy-Children-Global-Programme-Framework-2021.pdf

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"The National Environmental Health Survey is a survey on health in relation to exposure to environmental factors. The surveys have been conducted every fourth year since 1999 with the aim to follow the population's health status in relation to environmental factors and providing data that can be used for policy making, mainly at a regional level. The surveys are conducted by the Public Health Agency of Sweden in collaboration with the Swedish counties."

Office of the Ombudsman for Children, Sweden

At the same time, respondents also raised certain concerns regarding the overly general and even, sometimes, superficial approaches in policy documents with reference to environmental factors, which leads, respectively, to the lack of concrete measures and actions.

"The strategy for the realisation of children's rights emphasises the importance of environmental protection for the benefit of children but does not provide specific guidance on how environmental factors are taken into account in child health policies."

The Protector of Human Rights and Freedoms (Ombudsman), Montenegro

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"To date, reference to environmental factors in NI policies has been very limited; e.g. in the original Healthy Child, Healthy Futures framework document there was no reference to environmental factors such as air and water pollution, air and water quality etc. It is our understanding that there may be reference to environmental factors and climate change within the new Framework document, to be published in May 2025."

Commissioner for Children and Young People, Northern Ireland

Water quality and water-related diseases

Worldwide 785 million people today do not have basic access to water; 296 million people taking water from unprotected wells and springs; and 115 million people collecting untreated surface water from lakes, ponds, rivers and streams[52]. Millions of people rely on water sources that are at high or moderate risk of faecal contamination due to lack of toilets or poor sewer systems. Even water that is safe at its source (for example, from a water treatment plant or well) is at risk of becoming contaminated unless it is treated, transported, stored and handled safely. Chemical contamination is another real threat in many places across the world. Millions of people drink water containing arsenic or fluoride at levels designated unsafe by World Health Organization guidelines. The effects of climate change will only increase the threat to water quality, particularly where water is scarce or in regions that are prone to natural disasters. At any given time, 30 to 40 per cent of the rural water supply in low-income countries does not work. Some factors that affect the long-term sustainability of a water system include the reliability of the source, the transportation method, and affordability[53].

Thus, providing children with water in the necessary quantity and of adequate quality is directly connected to ensuring the child's right to health.

More than half of the jurisdictions included in the survey (59.3%) have well-planned and financed strategic actions, with strict monitoring of implementation. However, in 22.2% of responding jurisdictions, insufficient measures are being taken, and in 18.5% no measures are recorded, either due to lack of funds or a lack of strategic approaches in policy documents (Figure 18).

[52] https://www.who.int/news-room/fact-sheets/detail/drinking-water

[53] https://www.unicef.org/wash/water

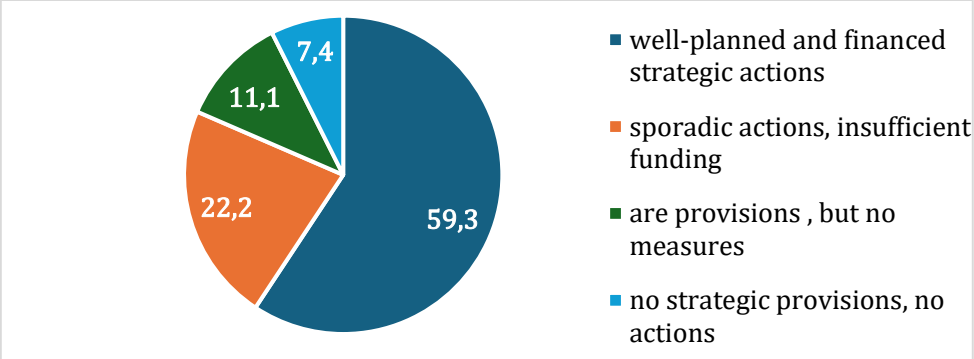

Figure 18. Plans/strategies to prevent death or injury of children as a result of water quality and water-related diseases in 27 jurisdictions, %.

The positive practices reported by some jurisdictions are to be appreciated.

> *"It is worth mentioning the "Friends of Water" project and the "World Water Monitoring Challenge", in accordance with the agreements signed between the Ministry of Education and Sports and Water Supply and Sewerage Association of Albania".*
>
> The People's Advocate, Albania
>
> #
>
> *"In order to implement the prevention of nitrate poisoning in drinking water, water from available wells and boreholes is tested at state funds for pregnant women and families with infants up to 6 months (Procedure for preventing nitrite and nitrate poisoning)".*
>
> The Ombudsperson for Children's Rights, Lithuania

Policy level approach

Climate change is one of the most pressing global challenges of our time, and its impact on children's health is particularly concerning. Children are more vulnerable to the health effects of climate change due to their developing immune systems, higher respiratory rates, and greater dependence on their environments. The environmental degradation associated with climate change – such as air pollution, extreme heat, water scarcity, food insecurity, and natural disasters – directly and indirectly affects children's physical health, mental well-being, and overall development.

A robust policy approach that addresses climate change while protecting and promoting children's health is essential. It must include mitigation strategies to reduce greenhouse gas emissions and adaptation strategies to protect children from the current and future impacts of climate change. This approach must be equitable, recognizing that children in vulnerable and low-income communities are disproportionately affected by environmental changes. It is important to ensure that children's health and well-being are prioritized in national climate change policies. This includes recognizing that children face unique vulnerabilities to climate-related risks, such as increased exposure to air pollution, heat, and waterborne diseases. Establish cross-sectoral policies that bring together public health, environmental, education, and child welfare sectors to create holistic climate policies that protect children's health.

Early warning systems should be developed for extreme weather events, such as heatwaves, floods, and wildfires, to protect children from the immediate health risks they pose.

Is it important to improve water and sanitation systems to ensure that children have access to safe drinking water and are protected from waterborne diseases, especially in areas vulnerable to flooding or drought due to climate change.

Adequate water treatment, wastewater management, and flood prevention infrastructure should be ensured to protect children from contaminated water sources, which are a significant source of illness.

Climate change education should be incorporated into school curricula to raise awareness of the challenges and solutions associated with climate change. Children need to be educated not only about the scientific aspects of climate change but also about how they can contribute to solutions, such as through sustainable behaviors, advocacy, and policy engagement. Climate literacy should be integrated from primary through secondary education, with a focus on developing critical thinking, problem-solving, and active citizenship skills.

2.9. Health Education

Public health problem

Globally, over 90% of children of primary school age, and over 80% of children of lower secondary school age are enrolled in school. By promoting healthy behavior from early childhood through the school setting, it would benefit not only the children themselves but also their families, peers and wider communities. In addition, schools are strategic platforms for delivering preventive health care services and these services can act as an extended arm of primary health care. Therefore, schools provide an efficient and effective way to reach large numbers of the population. In 1995, WHO launched its Global School Health Initiative with the purpose of encouraging the adoption of the health promoting school approach worldwide. Six key features of health promoting schools are: 1) healthy school policies; 2) physical school environment; 3) social school environment; 4) health skills and education; 5) links with parents and community; 6) access to (school) health services. From an educational point of view, schools contribute to health by: 1) creating the conditions for pupils' achievement through the school environment, with proven health benefits later in life; and 2) acquiring health competencies and promoting health literacy, with the aim of empowering young and future generations to make healthy decisions[54].

Survey results

From the responses provided by 27 jurisdictions, it is possible to conclude that training in the field of health and healthy behavior is approached on a broad and serious level. In 81.5% of the responding jurisdictions, there are special programs adapted to the specific age for each year of study. In 3 jurisdictions (14.8%), the general curriculum includes certain dedicated hours. It is an alarming answer that states that in the respective jurisdiction, there are no such hours in the children's school curriculum.

From Figure 16 it is possible to see the health subjects that are included in the curriculum at different stages of school education. Practically, all jurisdictions (26) reported that nutrition, physical activity and rest & sleep are mandatory components of the curriculum at the primary and secondary levels. At the secondary level, sexual and reproductive health (SRH) and addiction topics are widely included.

[54] https://www.emro.who.int/child-adolescent-health/information-resources/school-health.html

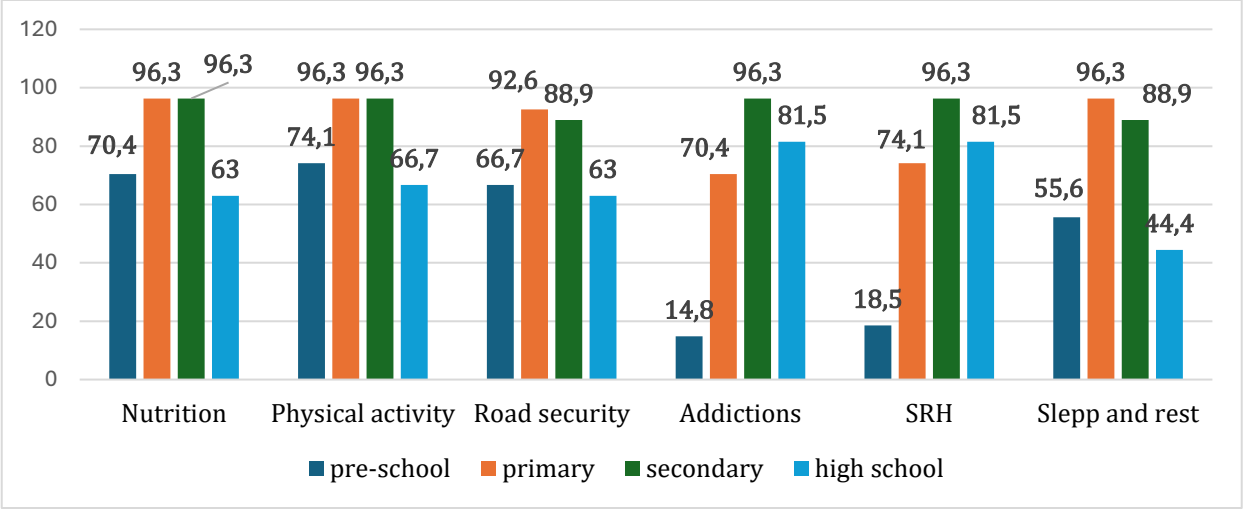

Figure 19. Curriculum on health education at different levels of education, 27 jurisdictions, %.

Many respondents shared their jurisdictions' achievements in implementing comprehensive health education programs for children.

"In Ukraine, health education is part of the school curriculum at different levels of education. From grades 1 to 9, children study the compulsory subject "Fundamentals of Health". In grades 10-11, health issues are integrated into the compulsory subjects "Biology" and "Physical Education".

The Parliament Commissioner for Human Rights, Ukraine

#

"Based on the key competencies of the pre-university education curriculum framework, health education as part of the school curriculum is addressed in all cycles of pre-university education, in the teaching programs and in the subjects: biology, physical education, sports and health, citizenship, technological training and psychology."

The People's Advocate, Albania

#

"*Starting from September 1, 2025, a new subject titled "Health Education" is planned to be introduced in Polish schools, replacing the current "Education for Family Life" curriculum. This subject will be taught in grades IV-VIII of primary schools and classes I-III of secondary schools. The curriculum will cover topics such as mental health protection, healthy nutrition, addiction prevention, and sexual education. The decision to make "Health Education" a non-compulsory subject has sparked criticism. Some fear that the curriculum may include topics they deem inappropriate or prefer to address at home. Despite these debates, "Health Education" is set to become an integral part of the educational program, aiming to equip students with knowledge and skills for lifelong health maintenance. It raises objections among some parts of Polish society because it contains information related to sexual education."*

The Ombudsman for Children, Poland

Health worker in schools

Children spend most of their time in school institutions, where they acquire the necessary knowledge but also need conditions for permanent monitoring of their health status. The presence of a health specialist / medical worker is very important and necessary for the implementation of educational activities, prevention and rehabilitation programs, but also for monitoring children's health.

Of the 27 jurisdictions included in the study, only one (3.7%) has a legal provision for the full-time presence of a medical worker (doctor, nurse or public health specialist) in schools. In 10 jurisdictions (37%), the medical worker is employed part-time, and in 4 jurisdictions (14.8%), this decision remains at the discretion of the administration of each educational institution. While in another 4 jurisdictions (14.8%) there are no such provisions for schools (Figure 17).

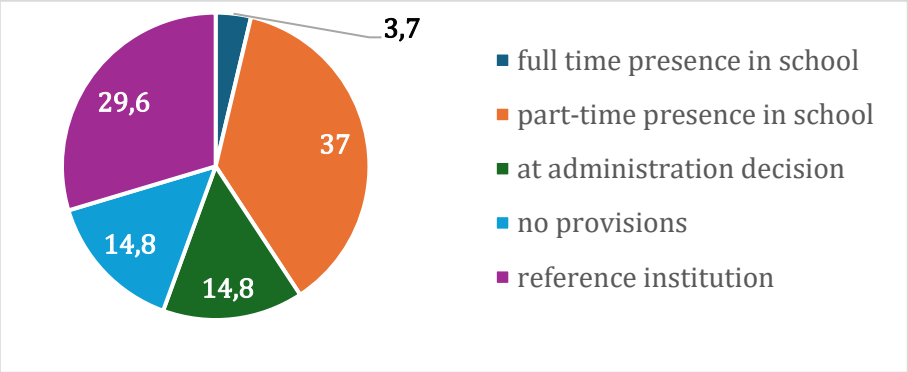

Figure 20. The presence of health workers in the schools, 27 jurisdictions, %.

8 jurisdictions (29.6%) have mentioned that health services are contracted or assigned to a nearby medical center / healthcare institution that is called upon when necessary.

> "*A public health center is assigned to each public school to guarantee the assistance and attention of any health issue of pupils. Some private schools have a medical worker.*"
>
> The Ombudsman's Office, Catalonia/Spain
>
> #
>
> *"Each school has a school medicine team consisting of a school doctor and a nurse. Their office is located outside the school premises, in the health center to which the school belongs territorially.''*
>
> The Ombudsman for Children, Republic of Croatia
>
> #
>
> *"The CLB "Centre for student guidance" is available for each school. These centres employ doctors, nurses, psychologists and social workers. They are not full-time present in the schools, but every school is supported by one of these centers, whose staff is at the disposal of every school. They conduct medical examinations, vaccinations, and offer guidance on various health-related issues. However, our office conducted a CLB last year and they are currently understaffed for their many tasks. "*
>
> The Children's Rights Commissioner, Flanders/Belgium

Policy level approach

WHO and UNESCO have launched a new initiative "Making Every School a Health Promoting School" through the development and promotion of Global Standards for Health Promoting Schools. Health Promoting Schools have been recognized as a strategic vehicle to promote positive development and health. The development of Global Standards for Health Promoting Schools will serve a common framework for both the health and education sectors to accelerate global progress and implement Health Promoting Schools in countries.

III. SPECIALISED HEALTHCARE SERVICIES FOR CHILDREN

3.1. Sexual and Reproductive Health

Sexual and reproductive health refers to a broad range of services that cover access to contraception, fertility and infertility care, maternal and perinatal health, prevention and treatment of sexually transmitted infections (STIs), protection from sexual and gender-based violence, and education on safe and healthy relationships.

Experiencing sexual and reproductive health means that a person has complete physical, mental and social well-being in all matters relating to their reproductive system and its functions. In everyday life, this means that people are able to have satisfying and safe sex lives, to have healthy pregnancies and births, and decide if, when and how often to have children.

Access to sexual and reproductive health services is a human right and should be available to all people throughout their lives, as part of ensuring universal health coverage. This not only contributes to improved health outcomes, but also to gender equality and wider development.

3.1.1. Maternal and neonate mortality

Public health problem

Even though medicine is making considerable progress worldwide, according to data provided by WHO data, maternal mortality remains unacceptably high. About 260 000 women died during and following pregnancy and childbirth in 2023. Approximately 92% of all maternal deaths occurred in low- and lower-middle-income countries in 2023, and most could have been prevented[55].

Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy and most are preventable or treatable. Other complications may exist before pregnancy but are worsened during pregnancy, especially if not managed as part of the woman's care. The major complications that account for around 75% of all maternal deaths are: severe bleeding (mostly bleeding after childbirth); infections (usually after childbirth); high blood pressure during pregnancy (pre-eclampsia and eclampsia); complications from delivery; unsafe abortion.

All women need access to high quality care in pregnancy, and during and after childbirth. Maternal health and newborn health are closely linked. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death for the women as well as for the newborns.

Factors that prevent women from receiving or seeking care during pregnancy and childbirth are:

- health system failures that translate to (i) poor quality of care, including disrespect, mistreatment and abuse, (ii); insufficient numbers of and inadequately trained health-care providers, (iii); shortages of essential medical supplies; and (iv) the poor accountability of health systems;
- social determinants, including income, access to education, race and ethnicity, that put some sub-populations at greater risk;
- harmful gender norms and/or inequalities that result in a low prioritization of the rights of women and girls, including their right to safe, quality and affordable sexual and reproductive health services; and

[55] https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

- external factors contributing to instability and health system fragility, such as climate and humanitarian crises.

In the table below we present official data on maternal and newborn mortality for Europe, including the ENOC member countries[56].

Table 8. Maternal mortality and neonatal mortality rates in Europe.

Country	**Maternal Mortality ratio** (per 100 000 live births) – **2020 year**	**Neonatal mortality rate** (per 1000 live births) – **2022 year**
Albania	7.03	6.99
Andorra	48.4	1.35
Armenia	43.3	5.55
Austria	5.55	2.06
Azerbaijan	21.1	13.2
Belgium	4.15	2.16
Bosnia and Herzegovina	7.41	4.6
Bulgaria	8.74	2.7
Croatia	5.2	2.85
Czech Republic	3.24	1.36
Cyprus	87	1.92
Denmark	4.08	1.89
Estonia	5.89	1.02
Finland	8.55	1.33
France	8.89	2.65
Germany	4.23	2.27
Georgia	29.7	5.38
Greece	7.2	2.33
Hungary	18.5	2.15
Iceland	11.8	1.33
Ireland	5.59	2.46
Italy	7.64	1.66
Latvia	21.1	1.65
Lithuania	8.11	1.99
Luxembourg	6.0	1.67
Malta	9.97	3.78
Moldova	28.5	10.82
Monaco	23.6	1.5
Montenegro	14.7	1.04
Netherlands	3.82	2.61
Norway	2.16	1.32
North Macedonia	7.11	1.92
Poland	2.95	2.54
Portugal	13.6	1.66
Romania	15.8	3.24
San Marino	45.9	0.64
Serbia	15.7	3.25
Slovakia	4.08	3.02
Slovenia	11.8	1.33
Spain	4.29	1.74
Sweden	5.2	1.42
Switzerland	5.29	2.83

[56] https://data.who.int/countries

UK and Northern Ireland	13.5	2.71
Ukraine	17.97	4.8

Policy level approach

To reduce maternal and neonatal mortality, states must implement the provisions of WHO *Strategies toward ending preventable maternal mortality*[57] that are grounded in a human rights approach to maternal and newborn health. Concrete political commitments and financial investments by country governments are necessary to meet the targets and carry out the strategies targets such as:

- addressing inequalities in access to and quality of reproductive, maternal and newborn health care services;
- ensuring universal health coverage for comprehensive reproductive, maternal and newborn health care;
- addressing all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities;
- strengthening health systems to collect high quality data in order to respond to the needs and priorities of women and girls; and
- ensuring accountability in order to improve quality of care and equity.

To avoid maternal deaths, it is vital to prevent unintended pregnancies. All women, including adolescents, need access to contraception, safe abortion services to the full extent of the law, and quality post-abortion care.

3.1.2. Adolescent pregnancy

Public health problem

Teenage live births

Adolescent pregnancy is a global phenomenon with clearly known causes and serious health, social and economic consequences. Globally, the adolescent birth rate (ABR) has decreased, but rates of change have been uneven across regions. There are also enormous variations in levels between and within countries. Adolescent pregnancy tends to be higher among those with less education or of low economic status. According to WHO data ss of 2019, adolescents aged 15–19 years in low- and middle-income countries (LMICs) had an estimated 21 million pregnancies each year, of which approximately 50% were unintended and which resulted in an estimated 12 million births. About 55% of unintended pregnancies among adolescent girls aged 15–19 years end in abortions, which are often unsafe in LMICs. Adolescent mothers (aged 10–19 years) face higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birth weight, preterm birth and severe neonatal condition[58]. Teen* pregnancies can influence women's education prospects, economic opportunities, and health. Although adolescent pregnancies, especially unintended pregnancies, might carry greater risk of adverse consequences in developing countries with limited resources and restrictive abortion laws, pregnancy and childbirth among young women in developed countries can also pose challenges to their social, economic and physical well-being.

[57] https://www.who.int/publications/i/item/9789241508483

[58] https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

Adolescents are often noted to have an increased risk of death during pregnancy or childbirth compared with older women. The children born are also more likely to be stillborn or die in the first month of life. Some evidence from both developing and developed countries also suggests that risks are greater for younger adolescents, with girls aged 15 years or younger having higher mortality than older adolescents[59]. In Europe, the unintended pregnancy rate declined by 53% over the past 30 years, while that of abortion declined by 64% (Figure 13)[60].

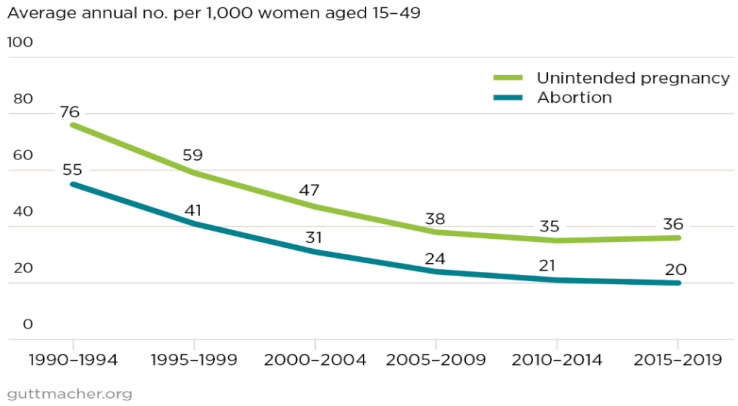

Figure 21. Incidence of unintended pregnancy and abortion in Europe, 1990-2019, %.

Even though a series of measures have been implemented that have essentially decreased the rate of unintended pregnancies, it is still a matter of concern in many European countries. According to data from the United Nations from 2015 to 2020, in European countries like the United Kingdom or France, 12 and 9 in every 1,000 women under 18 years had a delivery, respectively. These birth rates do not compare with those of low-income countries. An estimated 21 million girls aged 15 to 19 years in developing regions become pregnant every year, and approximately 12 million give birth. Although the issue of adolescent pregnancy represents a major issue in low-and-middle income countries. The higher rates of pregnancy in women aged 15–19 years have Eastern Europe (16.7 births per 1,000 women), when compared with Northern (8.29/1000), Western (7.35/1000) and Southern Europe (6.64/1000). On a closer look, the UK has registered one of the most important drops with a reduced rate of adolescent pregnancy by 51% from 1998 to 2014, due to its "Ten-year teenage pregnancy strategy for England" that improved access to contraception and increased the reach to young people and parents. On another note, Switzerland, since many years, exhibits the lowest rate of the world[61].

About 4% of women in the European Union (EU) who gave birth to their first child in 2015 were teenagers. In 2022, the share of births to teenage mothers in the European Union was below two percent. In the European region as a whole, this share was nearly 3.2 percent. The wider European region always recorded a higher rate of teenage births than the EU. Since the 1980s, births to adolescent mothers have declined nearly year-on-year in Europe, from almost ten percent in 1980 to three percent in 2021. Although progress has been uneven across regions and countries. Nearly ten percent of live births in

[59] Conde-Agudelo, A · Belizán, JM · Lammers, C.Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: cross-sectional study. *Am J Obstet Gynecol.* 2005; 192:342-349

[60] Unintended Pregnancy and Abortion in Europe. https://www.guttmacher.org/fact-sheet/unintended-pregnancy-and-abortion-europe

[61] Vieira M.M. et al. Adolescent pregnancy: An important issue for paediatricians and primary care providers—A position paper from the European academy of paediatrics. *Frontiers in Pediatrics,* 11, 2023. DOI=10.3389/fped.2023.1119500

Bulgaria were attributed to mothers under below the age of 20 in 2021. This was the highest share of births to teenage mothers in the European Union, followed by Romania and Slovakia. On the other hand, less than 0.5 percent of births in Norway, the Netherlands, and Switzerland were to teenagers[62].

In most circumstances, adolescent pregnancy results from lack of information and poor access to contraception. Teenage pregnancies must be viewed in the context of sexual and reproductive health (SRH) and rights, with the understanding that the social environment strongly influences teenagers' behavior. Reported teenage pregnancy rates are generally lower for countries where parental consent for abortion is not required, youth SRH services are available in all areas and contraceptives are subsidized for all minors, compared with countries where these conditions are not met. Vulnerability to pregnancy during teenage years in developed countries is primarily related to the use of effective contraception, which is promoted through social background factors such as sexuality education and access to youth-friendly SRH services.

Teenage abortions

Most teenage pregnancies in Europe are unplanned, resulting in many cases in pregnancy termination. Although the decision to pursue or end an unintended pregnancy mostly reflects changing social norms about teenage childbearing, the availability of legal abortion and confidential counseling also affects access to affordable and safe procedures, thus influencing the number of teenage pregnancies. The availability of abortion varies tremendously across Europe due to legal obstacles in some countries (abortion remains mostly illegal in three countries) or restrictive laws (imposing stringent gestational limits, parental consent and delays). Furthermore, reports of deteriorating access in some Eastern and Central European countries due to legislative initiatives, geographical disparities and increased costs of services potentially contribute to growing social inequalities, undermining young women's ability to access safe abortion services.[63]

While data on teenage live births are available across Europe, data on teenage abortions are unavailable or incomplete in more than one-third of European countries. It is difficult to obtain valid figures in this respect, but suffice is to say that adolescent abortions represent between 10 and 20 percent of all legal abortions registered in European countries[64]. The rate of abortions among 15- to 19-year-old adolescents varies 6 per 1,000 females (Germany) and ~20 (Hungary)[65].

Survey results

Of the 27 countries/regions that participated in the survey, only one-third (9) were able to provide figures on the number of abortions performed on minors (10 to 14-year-olds) and in only 12 countries are data available on abortions performed on 15 to 19-year-olds. The lack of a clear picture and strict separate evidence of the number of abortions by age may be a serious cause for the delay or absence of separate policies and concrete actions targeted at age groups to decrease this indicator.

It should be kept in mind however that there are still important differences between European countries in terms of access to abortion, which largely depend on their national health systems and legal framework. Despite the fact that most legislations guarantee some access to such intervention, it remains

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[62] https://www.statista.com/statistics/1424856/births-to-teenage-mothers-in-europe-trend/

[63] Part K. et al. Teenage pregnancies in the European Union in the context of legislation and youth sexual and reproductive health services. *Acta Obstet Gynecol Scand* 2013; 92: 1395–1406.

[64] https://www.frontiersin.org/journals/pediatrics/articles/10.3389/fped.2023.1119500/full#B19

[65] Sedgh G, Bankole A, Singh S, Eilers M. Legal abortion levels and trends by woman's Age at termination. *Int Perspect Sex Reproductive Health*. (2012) 38:143–53. doi: 10.1363/3814312

a fragile right in some European countries. Moreover, it should be stressed that, if performed by expert health professionals, abortion is safe and does not lead to unfavorable health consequences[66] .

Analysing the level of realisation of the right to sexual and reproductive health in the jurisdictions included in the study, we determined that there are certain differences.

It is worth mentioning the free access in all jurisdictions (100%).

It is important to note that free access to adolescent-friendly SRH services in conditions of confidentiality and anonymity is ensured in only 19 out of 27 jurisdictions. Problems are also identified when we analyse the organisation of services for groups living in remote regions, in terms of geographical access or those who have certain cultural or social particularities (ethnic communities). Not all jurisdictions have the necessary conditions in place to provide SRH assistance to adolescents with certain disabilities. Differences are also found in the provision of free contraceptives for adolescents, as well as the presence of a regulatory framework ensuring safe abortion services and post-abortion care, especially for adolescents (Figure 22).

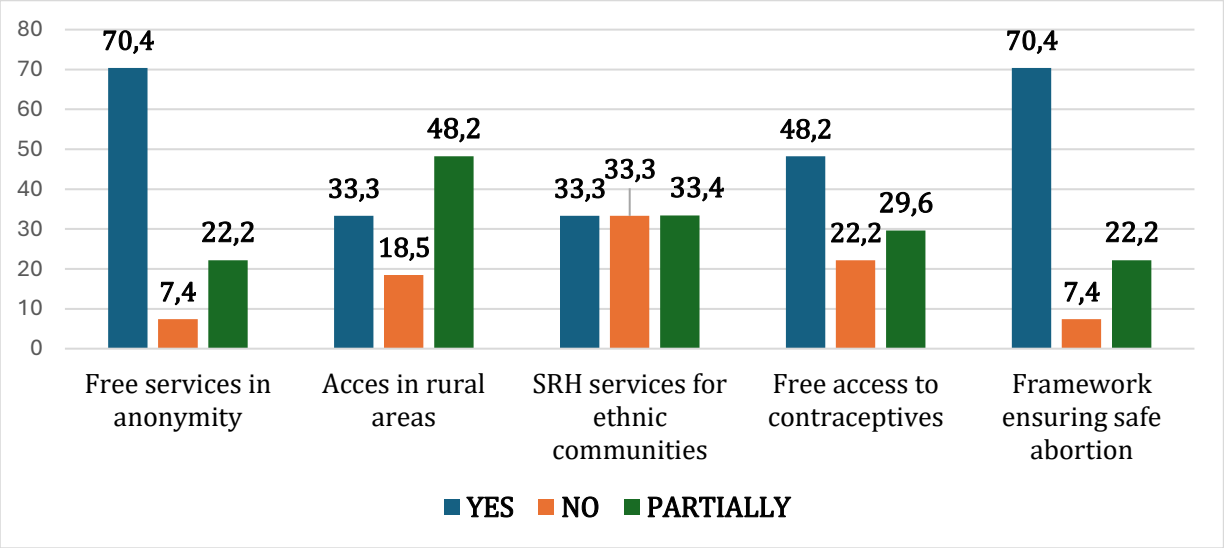

Figure 22. Ensuring the right to SRH for adolescents in 27 jurisdictions, %

Policy level approach

Even though the teenage pregnancy rates are declining, remarkable cross-country differences need to be explored further to reduce regional disparities in Europe, including equal access to abortion and youth SRH services. The collection of standardized statistics on teenage pregnancies is critically needed. Periodic estimation of pregnancies, births and abortions among adolescents can bring attention to countries where the levels of any of these events are exceptionally high or low and can motivate further research and policy action where needed. It is necessary to develop / apply monitoring tools and much clearer evidence of the number of abortions by age, in order to develop targeted policies and interventions, with much greater impact and efficiency in the target groups.

The states have to ensure free access to contraception for adolescents, open and easy access to youth-friendly health care to young women and their partners and facilitate their access to family

[66] Vieira M.M. et al. Adolescent pregnancy: An important issue for paediatricians and primary care providers—A position paper from the European academy of paediatrics. *Frontiers in Pediatrics,* 11, 2023. DOI=10.3389/fped.2023.1119500

planning counselling. It is important to specifically designate trained staff to convey accurate sexuality education and family planning in schools. Special programs are needed for adolescent mothers to support them by creating opportunities in employment, education and training. Promoting legal provisions at the national level that would liberalize and ensure free access to safe abortion.

3.1.3. Sexually transmitted diseases

Public health problem

Sexually transmitted infections (STIs) are considered a serious public health problem worldwide, affecting especially young people. The European Centre for Disease Prevention and Control (ECDC) has published its latest Annual Epidemiological Reports shedding light on the state of sexually transmitted infections (STIs) in the European Union/European Economic Area (EU/EEA). The findings reveal a troubling surge in cases of syphilis, gonorrhoea, and chlamydia, indicating a pressing need for heightened awareness of STI transmission, and the need to enhance robust prevention, access to testing, and effective treatment to address this public health challenge. In 2022, the number of reported cases saw a significant increase compared to the previous year, with gonorrhoea cases rising by 48%, syphilis cases by 34%, and chlamydia cases by 16%. In addition, cases of lymphogranuloma venereum (LGV) and congenital syphilis (caused by transmission from mother to fetus) have also substantially increased[67].

According to data from different European countries, the average age of first sexual intercourse has decreased over the last three decades, with increasing proportions of adolescents reporting sexual activity before the 16 years. The international monitoring data indicates that 70% of patients with STIs are aged between 15 and 24 years and the World Health Organization estimates that one out of 20 teenagers contract an STI each year[68]. Therefore, since today sexually transmitted infections continue to pose a serious public health problem, especially among the younger subjects. A real increase in incidence is due to the increased tendency to have promiscuous sex without using a condom. A lot of young people show disinterest regarding these infections; which is linked to a lack of information devoted to this subject. Condoms have also been reported to be primarily used as a contraceptive and not to prevent the occurrence of sexually transmitted diseases, and their use becomes irregular when other contraceptives are used. It's also important to point out that in most industrialized countries, where the widespread use of antibiotics in the past decades has led to a drastic reduction in the spread of STIs, there is now a marked increase in viral STIs such as genital herpes and warts, and the re-emergence of diseases almost completely disappeared, such as syphilis and lymphogranuloma venereum.[69, 70] Untreated STIs can have serious health consequences (e.g. pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility). The problem with most of STIs is that they can occur symptom-free and thus can be passed on unaware during unprotected sexual intercourse.

Survey results

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[67] https://www.ecdc.europa.eu/en/news-events/sti-cases-rise-across-europe

[68] Visalli G, Picerno I, Vita G, Spataro P, Bertuccio MP. Knowledge of sexually transmitted infections among younger subjects of the city of Messina (Sicily). *J Prev Med Hyg.* 2014 Mar;55(1):17-22.

[69] Trani F, Gnisci F, Nobile CG, et al. Adolescents and sexually transmitted infections:knowledge and behaviour in Italy. J Paediatr Child Health. 2005;41:260–264. doi: 10.1111/j.1440-1754.2005.00607.x.

[70] Arnold CA, Limketkai BN, Illei PB, et al. Syphilitic and lymphogranuloma venereum (LGV) proctocolitis: clues to a frequently missed diagnosis. Am J Surg Pathol. 2013;37:38–46.

The majority of Child's Ombudsperson Offices participating in the survey were unable to provide concrete data on the incidence of sexually transmitted diseases in their countries/regions, due to the lack of available data. The lack of this monitoring and evidence is a weak point for the development of concrete and effective policies and interventions targeted at specific age groups.

Policy level approach

The increasing trend of STIs underscore the urgent need for immediate action to prevent further transmission and mitigate the impact of STIs on public health, to increase public awareness, prevention, testing, and treatment efforts to address this growing public health concern.

Extensive and constant information on sexual practices of adolescents and, in particular, promotion of the knowledge regarding risk behavior related to unprotected intercourse would lead to the strengthening and dissemination of preventive measures and protection against STIs.

3.2. Diseases requiring rehabilitation services

3.2.1. Neurological and developmental disorders

Public health problem

Neurodevelopmental disorders are disabilities associated primarily with the functioning of the neurological system and brain. Examples of neurodevelopmental disorders in children include attention-deficit/hyperactivity disorder (ADHD), autism, learning disabilities, intellectual disability (also known as mental retardation), conduct disorders, cerebral palsy, and impairments in vision and hearing. Children with neurodevelopmental disorders can experience difficulties with language and speech, motor skills, behavior, memory, learning, or other neurological functions. While the symptoms and behaviors of neurodevelopmental disabilities often change or evolve as a child grows older, some disabilities are permanent. Diagnosis and treatment of these disorders can be difficult; treatment often involves a combination of professional therapy, pharmaceuticals, and home- and school-based programs.

A report published in 2023 by WHO and UNICEF highlights the global prevalence of developmental disabilities among children and young people, shedding light on the urgent action needed to address disparities in their access to healthcare, health outcomes, and exposure to social determinants such as poverty. Millions of children and young people affected by health conditions contributing to a developmental disability experience stigmatization, prejudice, and social exclusion. They also encounter barriers in accessing health care and experience poorer quality of care when compared with their peers[71].

Survey results

From the responses received from the jurisdictions, we note that there are still many gaps in addressing the problems of children with neurodevelopmental disorders. First of all, there is no clear evidence and monitoring of the number of children / people by type of neurodevelopmental disease. In majority of the jurisdiction this evidence is kept fragmented, or by several agents, without being able to present a clear picture with reference to the prevalence of this group of diseases at the country/region level.

[71] https://www.who.int/news/item/15-09-2023-new-reports-highlights-neglected-health-needs-of-children-with-developmental-disabilities

" *We have the numbers of children seeking medical care, but we do not have evidence of the number of children with neurological and developmental disorders to calculate the coverage rate*."

Office of the Ombudsman for Children, Sweden

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"It is difficult to provide exact figures on the number of children with neurological and developmental disorders in Flanders. Estimates indicate that there are between 25,000 and 30,000 children with a disability, which represents approximately 2 to 3 percent of all children. "

The Children's Rights Commissioner, Flanders/Belgium

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"Despite the existence of the Croatian Register of Persons with Disabilities, experts warn that the actual number of children with developmental and neurological disorders, particularly autism, may be significantly higher due to challenges in diagnostics, a shortage of specialists, stigma, and complex administrative procedures".

The Ombudsman for Children, Republic of Croatia

#

" *There is no single registry in Montenegro that records the number of children with neurological and developmental disabilities, making it difficult to accurately determine their overall prevalence. This information is fragmented and often unavailable, indicating the need to establish such a registry for better planning and provision of adequate services*."

The Protector of Human Rights and Freedoms (Ombudsman), Montenegro

#

"Luxembourg passed a new law on pupils' welfare and inclusive education on June 13, 2023. Despite this new law, the OKAJU still receives, on a regular basis, complaints when it comes to accessing mainstream schools for children with disabilities. There is no clear data on the number of pupils with disabilities included, whether through rehabilitation programmes, in mainstream school, and those not included."

The Ombudsman for Children and Adolescents, Luxembourg

It is becoming obvious that, without a clear database and a centralized system for recording and monitoring children with this type of disorders, it is practically impossible to achieve a proper planning and organization of the services and assistance needed by these patients. Many respondents confirm that the organization and access of patients with neurodevelopmental disorders is limited and insufficient.

"According to the Office of the Ombudsperson for Children, services for children with developmental difficulties are not equally accessible to all. Coverage is significantly better in larger and more developed cities, while children living in rural, isolated areas and on islands often face serious disadvantages. For example, children with developmental difficulties living on islands often have to travel to the mainland to access essential services. Another major issue is the overburdened capacity of institutions that provide diagnostic, rehabilitation, and educational services, leading to long waiting times for children to receive necessary support."

The Ombudsman for Children, Republic of Croatia

#

"However, ensuring the rights of these children goes beyond diagnosis, requires access to timely, appropriate, and quality rehabilitation and support services. While Georgia has made efforts through public programs (e.g., early screening and epilepsy management) that provide initial consultations, neuropsychological assessments, these services represent only a portion of the comprehensive care children may need. Access to multidisciplinary rehabilitation—such as physiotherapy, occupational and

speech therapy, or behavioral support—remains inadequate. Children in rural areas and regions face significant barriers to these essential services."

Office of the Public Defender, Georgia

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"*In 2023, 10,529 children and young people with a disability received support from a multifunctional center (MFC) in Flanders. These centers offer flexible, demand-driven programs for people with a disability up to and including 21 years of age, and in exceptional cases up to and including 25 years of age. There are challenges with regard to the accessibility of these services. Long waiting lists and an uneven geographical distribution of MFCs and rehabilitation centers make it difficult to access timely and appropriate care. In addition, there are long waiting times for diagnosis of developmental disorders, which delays access to necessary treatments."*

The Children's Rights Commissioner for Flanders, Belgium

#

"*These children would be covered -at least formally- by the necessary specific rehabilitation services since their needs have been properly identified, either by the school system or earlier- but a different issue is whether they are really receiving the necessary services, since our Institution is aware of delays, mainly due to the lack of sufficient resources to attend the existing demand, both at school and earlier.*"

The Ombudsman's Office, Andalusia

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"*In Poland, comprehensive nationwide data on the number of children with neurological and developmental disorders is limited. Comprehensive nationwide data on the coverage rate of rehabilitation services for children with neurological and developmental disorders in Poland is limited. Several initiatives and studies provide insights into the current landscape.*"

The Ombudsman for Children, Poland

Regarding the sustainable financing from public funds of programs intended for the care of children with neurodevelopmental diseases, we note that the situation is different in the jurisdictions included in the study. Only in a little over half of the jurisdictions (15 out of 27) are such programs available, fully funded from the state budget. In 11 jurisdictions (out of 27), even if such programs exist, they are not sufficient to cover the large number of requests from patients with various diseases or are insufficiently covered by funding from the public budget (Figure 23).

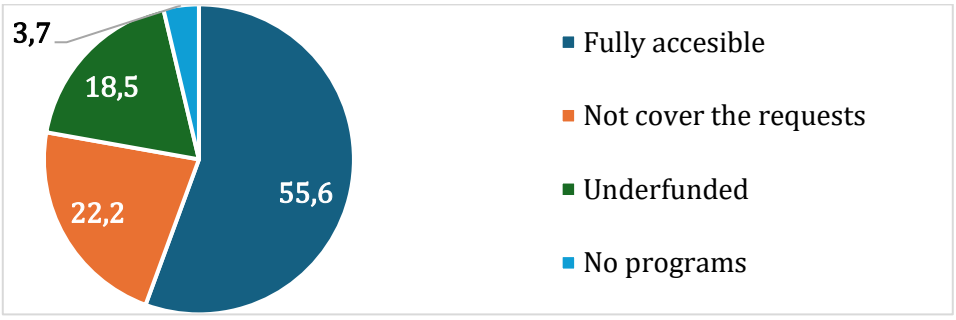

Figure 23. Public programs for children with neurodevelopmental diseases, 27 jurisdictions, %.

Policy level approach

It is necessary to build responsive multisectoral care systems for children and young people with developmental disabilities. States should adopt a concrete framework for action needed to accelerate

changes in policies to improve health, development, wellbeing, and participation for children with developmental disabilities by:

- Strengthen coordination and accountability mechanisms to improve care;
- Promote participation in advocacy, leadership, policy, programming and monitoring;
- Address the social determinants of health;
- Tackle stigmatization and foster inclusive enabling environments;
- Advance multisectoral policy-making to address inequities in healthcare;
- Deliver services for inclusive and people-centred evidence-based care;
- Inform, empower and support caregivers;

3.2.2. Children with disabilities

Public health problem

Locomotor disability refers to a person's inability to execute distinctive activities associated with movement of self and manipulation of objects resulting from affliction of musculoskeletal and/or nervous system. Locomotor disabilities refer to a broad spectrum of physical disabilities that impair the ability to move or walk. These disabilities can be congenital (present from birth) or acquired (developing later in life). The impact of locomotor disabilities on a child's life can vary greatly, depending on the severity of the condition, but they often affect not only mobility but also social interaction, educational participation, and overall quality of life. Some common examples of locomotor disabilities include: Polio, Rickets, Muscular Dystrophy, Cerebral palsy, Spina Bifida, etc. Understanding the nature of these disabilities is the first step in determining the appropriate interventions to support affected children. Early diagnosis and intervention is especially important in cases of degenerative conditions, where timely treatment can slow down progression and enhance quality of life. It is crucial to ensure that these children can access education and participate fully in all aspects of life. When it comes to supporting children with locomotor disabilities, the goal is to promote independence, mobility, and full participation in the educational experience. Various interventions can help achieve these goals, focusing on both medical management and the use of assistive devices.

The presence of care, rehabilitation and health support services is of major importance for respecting the right to life and health of children facing such diseases.

Assistive devices play a vital role in supporting the mobility and independence of children with locomotor disabilities. These devices range from basic aids like walking sticks to more complex equipment like wheelchairs and prosthetics. The right device depends on the child's specific needs and abilities, as well as the severity of their disability.

- **Wheelchairs:** For children who have significant difficulty walking, a wheelchair can be a life-changing device. It provides mobility, enabling children to move around independently and participate in classroom activities.
- **Prosthetics:** Prosthetic limbs can replace lost or non-functional limbs, allowing children to regain some of their lost function and participate in physical activities.
- **Orthotic devices:** These are worn to support weakened or abnormal joints and muscles. They can help improve mobility and prevent further physical complications.
- **Walking aids:** Children who can walk but need extra support may benefit from walking aids such as canes, crutches, or walkers, which reduce the risk of falls.

The use of assistive devices not only enhances mobility but also boosts the child's confidence and self-esteem, encouraging them to engage more actively in school and social activities.

Survey results

Not all jurisdictions participating in the survey have rehabilitation programs for children with locomotor disabilities that are fully funded from the public budget. In some, even if such programs exist, they are underfunded, creating the risk of discrimination and limiting children with such disabilities' access to needed services.

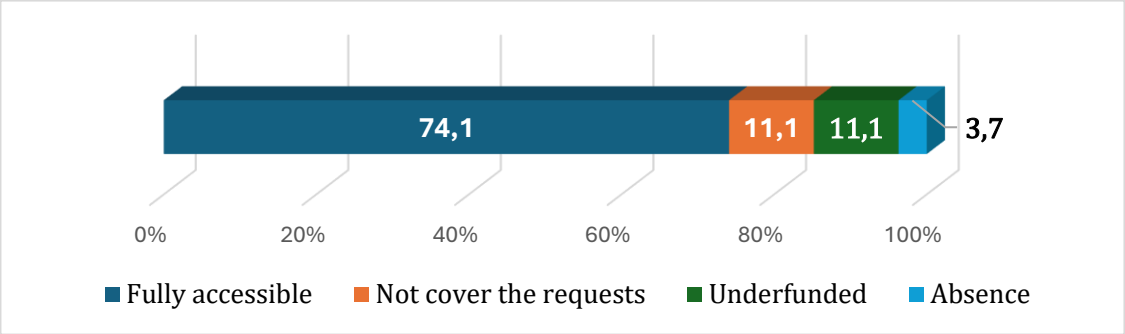

Figure 24. Rehabilitation programs for children with locomotor disabilities, 27 jurisdictions, %.

From the responses received in the survey, we note that the provision of wheelchairs to patients according to needs is not compliant in many responding jurisdictions. Provision of children with prosthetic items is reported in a much smaller number of jurisdictions, in most cases these items are only partially covered by public funds or not at all.

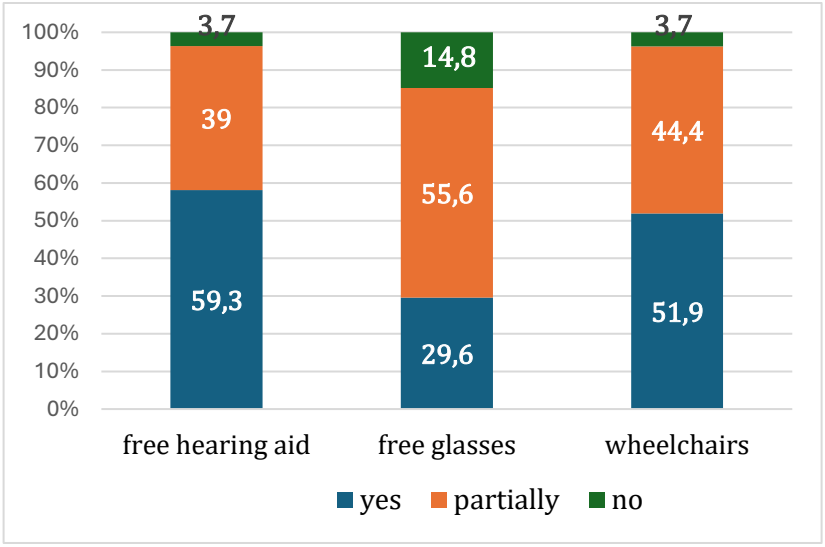

Figure 25. Free of charge prosthetic items and wheelchairs, 27 jurisdictions, %

"As for assistive items, including hearing aids, eyeglasses, wheelchairs, and mobility-supportive equipment, access depends on factors such as: confirmation of disability status by the State Agency, inclusion in a specific social assistance program (e.g., the "Child with Disability" or "Severe Disability" categories). The process for obtaining assistive items typically involves assessment, which may result in waiting times, limited customization, or provision of comparative lower-quality items. Geographic and socioeconomic gaps further limit equitable access, with children in rural and remote regions facing additional barriers. Overall, while the government has mechanisms to support children's access to essential health items, the support is insufficient to fully meet the needs of the children's population, particularly for children with disabilities or chronic conditions."

The Office of the Public Defender of Georgia

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"If necessary, foot inserts and complex orthopedic footwear may be reimbursed every six months, however, the base price of the first pair of footwear is reimbursed from MHIF funds at 100 percent, and the base price of the second pair produced during the same year is 70 percent. Foot inserts are reimbursed at 100 or 80 percent of the base price, depending on the social group."

The Ombudsperson for Children's Rights, Lithuania

Policy level approach

The Convention on the Rights of Persons with Disabilities (CRPD) and the Convention on the Rights of the Child (CRC) provide detailed guidance for the development of inclusive societies. The ratification alone of these Conventions will not be enough. The process of honoring commitments in practice will require effort on the part of national governments, local authorities. Discrimination lies at the root of many of the challenges confronted by children with disabilities and their families. The principles of equal rights and non-discrimination should be reflected in law and policy and need to be complemented by efforts to enhance awareness of disability among the general public, starting with those who provide essential services for children in such fields as health, education and protection[72].

3.3. Other specialized services

3.3.1. Children and adolescents with HIV/AIDS

Public health problem

Worldwide, an estimated 1.4 million children aged 0-14 were living with HIV at the end of 2023, and 120 000 children were newly infected. An estimated 76 000 children died of AIDS-related illnesses. Globally in 2023, an estimated 1.5 million adolescents (10-19 years old) were living with HIV and an estimated 140 000 were newly infected with HIV. To reduce HIV-related mortality and morbidity among this highly vulnerable population, early testing and treatment is essential. Without access to testing and treatment, 50% of children with HIV will die by the age of 2, and 80% will not live to their fifth birthday. Children living with HIV should start antiretroviral treatment (ART) immediately. Yet in 2023, only 57% of children were on ART, compared to 77% of adults. Once treatment begins, children must take their medicine regularly to stay healthy into adolescence and adulthood. Failure to suppress the HIV virus

[72] UNICEF. Children with Disabilities. https://www.unicef.org/media/84886/file/SOWC-2013.pdf

remains a serious problem among children, aggravated by a lack of child-friendly formulations of the newest and most effective antiretroviral drugs designed for adults. [73]

At the European level, in 2022, 110 486 HIV diagnoses were reported in 49 of the 53 countries in the Region, including 22 995 from the countries of the EU/EEA. This corresponds to a crude rate of 12.4 HIV diagnoses per 100 000 population in the Region overall, a slight increase on the rate for 2021 (11.9 per 100 000 population). However, this represents a substantial decrease on the rate for 2019 (15.6 per 100 000 population), which was the period before the COVID-19 pandemic. When comparing the number of HIV diagnoses to the estimated number of new HIV infections over the past decade, it is evident that an increasingly larger number. The population of people living with undiagnosed HIV is growing (table 9)[74].

Eastern Europe and Central Asia are two regions where overall HIV prevalence has not declined in recent years. In the EU/EEA and countries in the West of the Region, the significant upsurge in previous positive HIV diagnoses overall has reshaped the epidemiological landscape. Much of this increase can be attributed to an influx of individuals living with HIV arriving from various countries and regions, including Ukraine, introducing new challenges for HIV care as well as mental health and social support needs. Further to migrants, over the past decade, the primary route of transmission in the EU/EEA and West remains sex between men.[75] Migrants are a key population affected by HIV across Europe [76].

Despite universal access to testing and antiretroviral treatment, too many people in the eastern part of the Region remain undiagnosed. As a result, people develop AIDS and die from AIDS-related causes in this subregion. Limited access to treatment and care, fear of discrimination, and criminalization of HIV transmission collectively reduce the incentive for HIV testing. Around 40% of all people living with HIV in eastern Europe and central Asia are still not receiving ART.[77]

Table 9. Characteristics of new HIV and AIDS diagnoses reported in the WHO European Region, the EU/EEA, and West, Centre and East of the WHO European Region in 2022.

[73] https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/hiv/treatment/treatment-and-care-in-children-and-adolescents

[74] HIV/AIDS surveillance in Europe 2023. https://www.ecdc.europa.eu/sites/default/files/documents/HIV-AIDS_surveillance_in_Europe_2023_(_2022_data_)_0.pdf

[75] UNICEF. Children, HIV and AIDS Regional snapshot: Eastern Europe and Central Asia. https://www.ecdc.europa.eu/sites/default/files/documents/HIV-AIDS_surveillance_in_Europe_2023_(_2022_data_)_0.pdf

[76] European Centre for Disease Prevention and Control . HIV and migrants. https://www.ecdc.europa.eu/en/publications/hiv-migrants-monitoring-implementation-dublin-declaration-2018-progress-report. Accessed January 10, 2020.

[77] https://www.who.int/europe/news-room/fact-sheets/item/hiv-aids-in-the-who-european-region

	WHO European Region	West	Centre	East	EU/EEA
Reporting countries/number of countries[a]	49/53	21/23	15/15	13/15	30/30
Number of HIV diagnoses	110 486	22 397	8 945	79 144	22 995
Rate of HIV diagnoses per 100 000 population	12.4	5.1	4.5	30.7	5.1
Percentage age 15–24 years	5.7%	8.9%	11.7%	4.2%	8.9%
Percentage age 50+ years	16.7%	21.8%	15.1%	15.5%	19.9%
Male-to-female ratio	1.8	2.4	2.9	1.6	2.4
Percentage of migrants[b]	26.7%	52.3%	27.0%	2.2%	48.3%
Transmission mode					
Sex between men	11.3%	35.2%	18.7%	3.7%	33.3%
Heterosexual transmission (men)	31.7%	15.1%	14.9%	38.3%	14.6%
Heterosexual transmission (women)	29.5%	21.0%	10.5%	34.1%	19.0%
Injecting drug use	16.1%	3.8%	2.1%	21.1%	4.3%
Mother-to-child transmission	0.6%	1.1%	0.8%	0.4%	1.2%
Unknown	10.8%	23.6%	52.8%	2.4%	27.3%
AIDS and late HIV diagnosis					
Percentage HIV diagnoses $CD4 < 350$ cells/mm^3	50.6	46.2	44.5	55.1	47.9%
Number of AIDS diagnoses[c]	7 220	1 873	825	4 522	2 349
Rate of AIDS diagnoses per 100 000 population	1.1	0.5	0.4	4.4	0.6

a No data reported by Andorra, Monaco, Turkmenistan and Uzbekistan.

b Migrants defined as originating from outside of the country in which they were diagnosed

c No data reported by Andorra, Bosnia and Herzegovina, Germany, Monaco, North Macedonia, Russian Federation, Sweden, Turkmenistan or Uzbekistan.

Compared to other populations, adolescents face additional barriers in accessing testing and treatment, including health services that are not adapted to their needs and policies that require parental consent for services. Adolescents living with HIV are also less likely than adults to adhere to their treatment, resulting in lower rates of viral suppression and lower declines in mortality. The risks and vulnerabilities associated with adolescents overall are even greater among those who belong to one or more key population groups, because they face multiple barriers to essential prevention and treatment services due to punitive laws, discrimination and stigma around behaviours such as illicit drug use and certain kinds of sexual activity. Late HIV testing is a key challenge throughout the region. Although infections tend to occur as a result of behaviours initiated during adolescence, the HIV diagnosis tends to be established at a later stage. Many countries fail to recognize that raising awareness among young people and offering them better access to early HIV testing are critical. Halting overall HIV epidemics throughout the region requires targeted prevention and treatment interventions that aim to expand safe and consistent access to essential HIV services among such highly vulnerable populations.

Survey results

The respondents to the survey confirmed to us that in most cases the programs for children with HIV/AIDS at all levels of prevention, treatment, care and support are covered by public funds or other additional funds, as described by the Republic of Moldova.

> *"There is the national program for the prevention and control of HIV/AIDS and Sexually Transmitted Infections, it is closely related to the financing received by the Republic of Moldova from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Funding comes from various sources, including the state budget, the Mandatory Health Insurance Fund and external funds."*
>
> People's Advocate for child's rights, Republic of Moldova

Despite the existence and availability of antiretroviral treatment programs, the continued high statistical data on HIV infection, including among adolescents, indicates the need for additional measures to increase information, awareness and early diagnosis of the infection in the population, especially in migrants and youth.

Policy level approach

To improve HIV prevention in migrant populations, countries should explore the feasibility of expanding primary prevention services, including condom provision programmes and pre-exposure prophylaxis (PrEP) implementation, to ensure that these are accessible to migrants. Availability of and access to testing and treatment, irrespective of residential and migrant status, can help further improve prevention and treatment of HIV infection. Countries should address wider barriers to HIV care and general information surrounding access to the healthcare systems. Improved monitoring and surveillance, particularly of previous positive cases, is needed to adequately capture and report these cases. WHO recommends that infants born to mothers living with HIV are tested for HIV by two months of age, during breastfeeding, and when breastfeeding ends given continued risk of transmission during this period. Older children, especially offspring and siblings of persons infected with HIV, should also be tested in high prevalence regions. Community-based outreach and testing can improve access to testing while mitigating HIV-related stigma. Improved prevention for MSM should include comprehensive programmes with expanded access

Addressing the distinct and diverse needs of adolescents living with HIV to improve their HIV-related outcomes requires a comprehensive and integrated approach that leverages on global commitments and approaches to adolescent health, including the *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)* and the *Global Accelerated Action for the Health of Adolescents* (AA-HA!). WHO recommends the implementation of adolescent-friendly health services in HIV services to ensure engagement and improved outcomes. Involving and engaging in their own care across the treatment cascade and through the cycle of planning, implementing, monitoring and evaluating programs is key. Peer-driven, adolescent-friendly services, integrated with other services including psychosocial interventions, are effective ways to improve health outcomes for adolescents.

3.3.2. Pediatric Palliative Care

Public health problem

Palliative care for children represents a small and highly specialized field of health care that is different from, albeit closely related to, adult palliative care. Ideally, support for children with palliative care needs starts at diagnosis, and for many children with life-limiting conditions this can be at birth.

Palliative care for children is the active total care of the child's body, mind, and spirit, and also involves giving support to the family. It begins when illness is diagnosed and continues regardless of whether or not a child receives treatment directed at the disease.

There is a large burden of suffering among children with severe physical disabilities. Although the range of diagnoses is large and diverse, there are common types of suffering experienced by children with disabilities that can be relieved through palliative care approaches. Whether the disability is due to a traumatic injury, congenital anomaly or genetic condition, pain and social isolation and stigmatization are common. Other chronic physical or psychological symptoms may be present depending on the specific condition. In addition, whenever a child is permanently unable to feed or wash herself, walk or use the toilet independently, this may cause physical, financial and emotional burdens for the family, especially a rural poor family. Palliative care providers may be the only source of relief for these types of distress.

Pediatric palliative care addresses serious medical conditions, including genetic disorders, cancer, prematurity, neurologic disorders, heart and lung conditions and others. It relieves the symptoms of these

diseases, such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and difficulty sleeping, anxiety and depression. In short, it helps the child, and the family improve their quality of life. Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.

Globally, the number of children – neonates, infants, children, and adolescents up to 19 years of age – who need pediatric palliative care (PPC) each year may be as high as 21 million. Another study found that almost 2.5 million children die each year with serious health related suffering and that more than 98% of these children are in low- and middle-income countries. While estimates differ, there is no doubt that there is an enormous need for prevention and relief of suffering among children for PPC.[78]

In the WHO European Region, it is estimated that 170 000 children in need of palliative care die each year. Data on palliative care services from the Region suggest that palliative care is available in 20 countries, with the majority of these geographically located in high-income western European countries. Palliative care is less well-developed in low-to-middle-income countries in the Region[79].

Survey results

During the survey, we determined that in 17 out of 27 jurisdictions there are programs dedicated to palliative care for children with incurable diseases, financed from public funds.

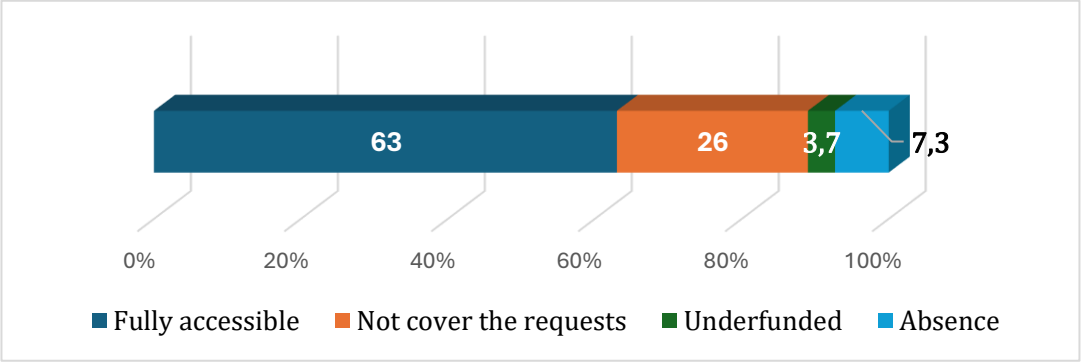

Figure 26. Programs for children with incurable diseases requiring palliative care, 27 jurisdictions, %.

The international studies and surveys present that, unfortunately, pediatric palliative care has not been seen as a priority around the world. A 2011 study found no PPC services in 65.6% of countries. Where services do exist in low-to-middle-income countries, they typically are available in only one or a few institutions and are not integrated into healthcare systems.[80]

Policy level approach

The pediatric palliative care is essential to ensure that children with life-limiting or life-threatening conditions receive comprehensive, compassionate, and coordinated care. Pediatric palliative care focuses not only on symptom management but also on improving quality of life, supporting the family, and respecting the child's rights and dignity. This framework aims to ensure that palliative care is integrated into healthcare systems, accessible to all children in need, and aligned with children's rights and ethical

[78] Integrating palliative care and symptom relief into paediatrics: a WHO guide for health care planners, implementers and managers. WHO, 2018.

[79] https://www.who.int/europe/news-room/fact-sheets/item/palliative-care-for-children

[80] Integrating palliative care and symptom relief into paediatrics: a WHO guide for health care planners, implementers and managers. WHO, 2018.

standards. In response to the large-scale unnecessary suffering of children, the 2014 *World Health Assembly Resolution WHA67.19 on Strengthening of palliative care as a component of comprehensive care throughout the life course*[81] emphasizes that access to palliative care for children is an "ethical responsibility of health systems". Pediatric palliative care should be integrated into all sectors and all levels of child health care, and it should be integrated with many types of potentially curative and life-sustaining treatments.

In addition, clear plans should be put in place to make sure palliative care continues without interruption when children with long-term palliative care needs become adults.

In low-to-middle-income countries, efforts to integrate palliative care into health care systems should always be accompanied by efforts to maximize accessibility of prevention, early diagnosis and treatment of serious and life-threatening illnesses

3.3.3. Rare diseases and intolerances

Public health problem

Rare diseases

There are between 6,000 to 8,000 life-threatening and chronically debilitating rare diseases (RDs) that affect less than 1 in 2,000 people, according to the European Commission. Only about 5% of rare diseases currently have approved treatments. The therapeutic options for rare diseases are limited because diagnosis is difficult and underreported. Rare diseases are characterized by a wide diversity of symptoms and signs that vary from disease to disease and from patient to patient suffering from the same disease. Children with rare diseases tend to be geographically widely distributed. Medical professionals often lack the appropriate training to recognize them. [82]

There are estimated to be between 6000 and 8000 known rare diseases in the world, many of which are predominantly paediatric disorders. About 75% of the diseases meeting the criteria for RD affect children, and about 30% of all patients with rare diseases die before their fifth birthday. Approximately 80% of rare diseases have a defined genetic basis. The true incidence and prevalence of individual rare diseases are often unclear. When the condition is fatal in childhood or early adult life, the prevalence in the population will be well below the birth incidence and will not reflect the gene frequency. RDs may affect as many as 30 million Europeans, with at least 3 million in the UK and 4 million in Germany, and this statistic has not been lost on the European Union (EU). [83]

Although individually rare, the cumulative burden of RDs is significant. The Council of the European Union states "*Rare Diseases are a threat to the health of EU citizens in so far as they are life threatening or chronically debilitating diseases with a low prevalence and a high level of complexity*". In 2009 the European Rare Diseases Patients Organisation (EURORDIS) published the "Voice of 12,000 patients". Individuals with a rare disease and their families reported on years of waiting for a diagnosis, after

[81] https://apps.who.int/gb/ebwha/pdf_files/wha67/a67_r19-en.pdf
[82] UNICEF. Precision health for children and adolescents: Rare diseases. https://www.unicef.org/innovation/media/20416/file/SDG%203%20Rare%20Diseases.pdf.pdf
[83] Dodge, J. A., Chigladze, T., Donadieu, J., Grossman, Z., Ramos, F., Serlicorni, A. (2010). The importance of rare diseases: from the gene to society. Archives of Disease in Childhood, 96(9), 791–792. doi:10.1136/adc.2010.193664

misdiagnosis and numerous physicians' visits. Some were rejected by health care professionals because of the complexity or associated symptoms. [84]

Intolerance

Adverse food reactions have become an important health concern in pediatrics, being an umbrella term to describe an abnormal reaction to food or single food components and includes food allergy (FA), food intolerance, and hypersensitivities. FA is defined as an adverse health effect arising from a specific immune response occurring reproducibly on exposure to a given food and can be classified according to the nature of the immune response. Currently, the prevalence of food allergy in Europe is estimated to be 0.1–6%. The term food intolerance (FI) covers various non-allergic reactions to food. The underlying pathophysiology can be attributed to the reduced ability of the intestine to digest and absorb a certain food component, and a mismatch between supply and possible breakdown in the gut. Although the underlying cause (intolerance, functional disease, lifestyle) remains unclear, it demonstrates that the number of children and adolescents avoiding foods without guidance and the possible negative impact on health should not be underestimated. Awareness on this matter must be raised in pediatricians to ensure that avoidance of foods and specific diets are directly addressed and further investigations or nutritional guidance is advised.

Survey results

Only 12 out of 27 jurisdictions have funded programs to care for children with rare diseases, and in 11 jurisdiction there are program for children with intolerances financed from public budget. Some respondents shared the challenges these patients face in their jurisdictions.

> "*State-funded treatment is available for some rare diseases for children, but many drugs (for ultra-rare diseases) are not fully reimbursed. Furthermore, high-cost medications (e.g., gene therapy) often require case-by-case approval and are subject to budget limitations. In some cases, additional support by NGOs is necessary. Children with certain food intolerances (e.g., lactose intolerance, gluten intolerance/celiac disease) receive partial support, but there is no comprehensive state-funded program covering all intolerances. State-funded diagnostic tests for some conditions (e.g., celiac disease, lactose intolerance) if referred by a doctor. Children diagnosed with celiac disease receive partial reimbursement for gluten-free products (e.g. flour) under a government program, meanwhile other food intolerances (e.g., lactose intolerance) do not qualify for financial aid.*"
>
> The Ombudsperson for Children's Rights, Lithuania

[84] European Academy of Pediatrics. https://www.eapaediatrics.eu/rare-diseases/

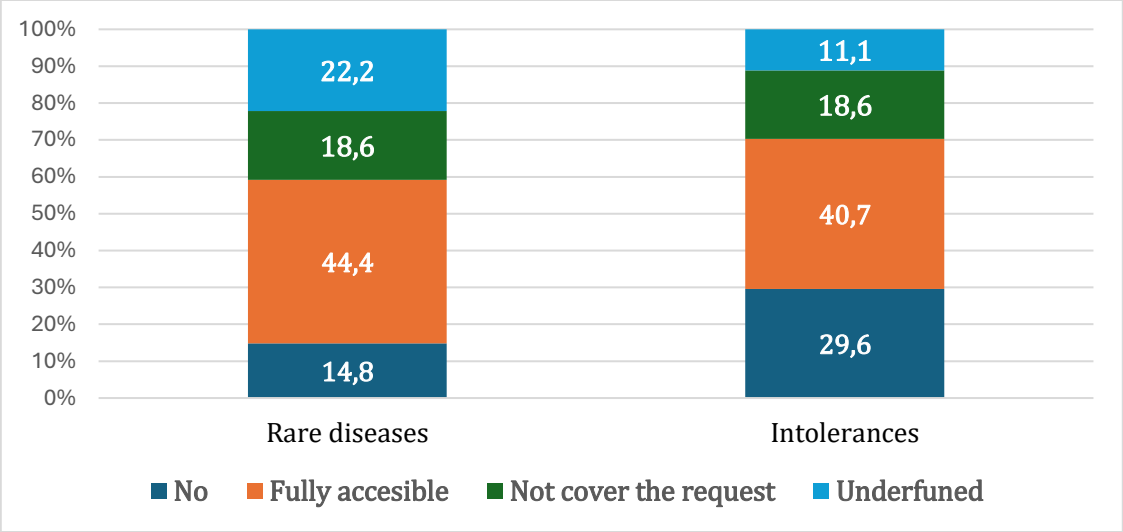

Figure 27. Programs for children with rare diseases and for intolerances, 27 jurisdictions, %.

Positive practices were also identified in providing patients with rare diseases with the services necessary for their health.

> *"4.2 million euros allocated by Ministry of Social Affairs for the next 4 years, part of which will fund medications for rare diseases that start in childhood. Starting from 2024, the government launched a new program to further cover the costs of medications, special foods, medical services, and other supportive services for children with rare diseases and diseases that begin in childhood. The funds will be distributed to charitable foundations that support children with rare diseases and their families (i.e., non-profit organizations or foundations registered in Estonia that have previously supported children with rare diseases and their families through charitable actions for the same purpose)."*
>
> Office of the Chancellor of Justice, Child's and Youth' Rights Department, Estonia

Policy level approach

A Committee of experts on rare diseases (EUCERD) was set up in November 2009 to assist and advise the European Commission, including, inter alia, drawing up guidelines and recommendations for implementing EU policies relating to RDs. To ensure respect for the right to life and health of children suffering from rare diseases, it is important that states take a comprehensive approach to this problem, namely:

✓ Provide sufficient services for expert diagnosis or confirmation of diagnosis.
✓ Ensure appropriate capacity and equal access to follow-up and management of children with rare diseases.
✓ Produce and adhere to good practice guidelines and implement outcome measures and quality control.
✓ Use and demonstrate a multidisciplinary approach in management of patients and families.
✓ Document and maintain a high level of expertise through publications, grants or honorary positions, teaching and training activities.
✓ Make a strong contribution to international research and support international trials of treatment of rare diseases

✓ Provide epidemiological surveillance, such as by registries, preferably at a European level.
✓ Communicate with health authorities and policy makers in order to improve the fi nances for healthcare of children with rare diseases.
✓ Support, communicate with and advise patient rare disease networks and organisations.
✓ Collaborate with initiatives of the European Commission Rare Disease task force in developing national plans for integrated services and support for patients and families affected by rare diseases.

3.3.4. Diabetes in youth and children

Public health problem

Worldwide, the number of children, adolescents and young adults living with diabetes is increasing rapidly. Type 1 diabetes (T1D) is the most common form of youth-onset diabetes, and the Europe Region has the highest number of children and adolescents living with the condition as well as the highest incidence annually (31,000)[85]. The estimated diabetes prevalence (9.8%) and the number of people with diabetes (66 million) in the Europe Region will see a 10% increase by 2050. The Region has the highest number of people with type 1 diabetes (2.7 million), 15% of whom are aged under 20 years (419,000). 1 in 7 live births are affected by hyperglycaemia in pregnancy[86].

Although type 2 diabetes (T2D) is far less common than T1D in childhood, an increasing trend in its prevalence in the paediatric population has been recorded over the past 30 years. Four decades ago, "juvenile diabetes" referred to type 1 diabetes and "adult-onset diabetes" was synonymous with type 2 diabetes. Today, incidence of type 2 diabetes in adolescents is twice that of type 1 diabetes in several non-White racial and ethnic groups and has, only recently, become recognized as a pediatric disease in clinical settings. While youth-onset type 2 diabetes is still relatively rare, any occurrence of this condition in children and adolescents is concerning given its aggressive clinical course, association with risk of debilitating complications by young adulthood, and high all-cause mortality. T2D in children results from complex interactions between social, behavioural and environmental factors that affect genetically-susceptible individuals. Some of the key risk factors include: race and ethnicity; obesity, diet, low levels of physical activity and sedentary lifestyle etc.[87]

It is estimated that one in three adolescents with T1D (aged 10-20 years), one in three adolescents and young adults with T2D (aged 13-21 years) and up to 60% of young adults (aged 18-30 years) report elevated diabetes distress, with prevalence rates for depression among young persons ranging from 17% to 63%. Studies have also found that children and adolescents with diabetes have increased rates of eating disorders rates compared to those without diabetes. Given the critical influence of mental health on people leaving with diabetes, self-management, psychological assessment and support should always be incorporated in diabetes care[88].

With nutrition and physical activity being cornerstones of diabetes management, young patients should also have access to paediatric specialist diabetes dietitians, and exercise should be discussed as part of their routine diabetes care. In this context, nutritional care should take into consideration

[85] https://idf.org/europe/news/diabetes-in-youth/
[86] https://diabetesatlas.org/data-by-location/region/europe/
[87] https://diabetesjournals.org/care/article/46/3/490/148482/Youth-Onset-Type-2-Diabetes-The-Epidemiology-of-an
[88] https://idf.org/europe/news/diabetes-in-youth/

important contextual factors such as the role of the family and the community in which young persons live, their traditions and socioeconomic status.

Access to the appropriate technology for blood glucose monitoring and insulin delivery for young persons can play a key role in helping them and their families managing the condition. For example, continuous glucose monitoring systems (CGM) can significantly alleviate diabetes distress, worries and hypoglycaemia, and subsequently improve general well-being. Similarly, the use of insulin pumps can increase autonomy in diabetes management and decrease diabetes burden.

Survey results

In most of the jurisdictions included in the study (21 out of 27), publicly funded programs dedicated to the care of children with diabetes are implemented. However, in some cases, certain problems are identified in ensuring access to necessary services for children with diabetes.

> "*We have concerns about availability of insulin pumps for children with diabetes. Significant delays in accessing diagnosis and support for children with neurodivergent conditions.*"
>
> Children and Young People's Commissioner, Scotland

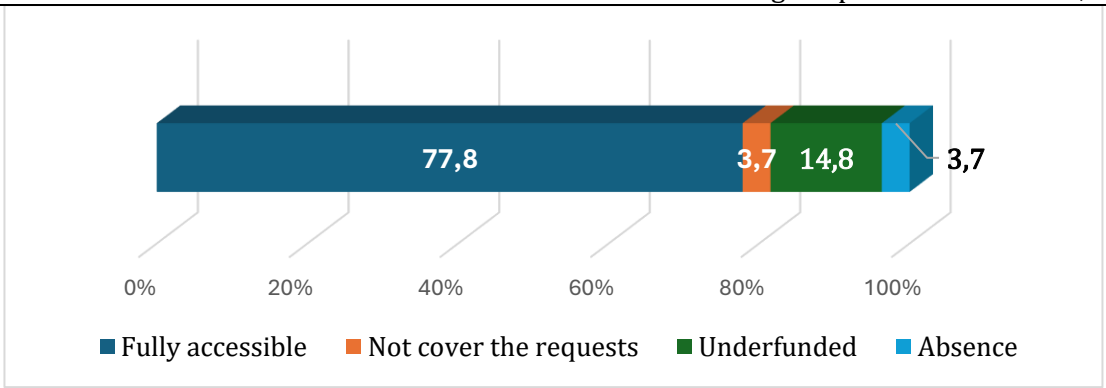

Figure 28. Programs for children with diabetes, 27 jurisdictions, %.

Policy level approach

The European Parliament (EP) has passed a significant resolution on "prevention, management, and better care of diabetes in the EU." Article 7 of the EP's World Diabetes Day resolution (2022) calls on Member States "*to develop, implement and monitor national diabetes plans and strategies with comparable milestones and targets, including a risk-reduction and screening/early action component…*".

The policy-level approach to diabetes in children requires comprehensive, coordinated action that spans prevention, early detection, clinical care, psychosocial support, and social inclusion. The rising burden of type 1 diabetes (T1D) and growing concerns over type 2 diabetes (T2D) in children (linked to obesity and lifestyle factors) demand urgent attention from health systems, education sectors, and governments. Policies and campaigns should be developed aiming for the primary prevention of diabetes at national or regional levels, as a part of a plan for the overall prevention of non-communicable diseases that share similar risk factors. Such prevention programmes should cover five key risk factors: promotion of healthy eating and physical activity, reduction of overweight and obesity, smoking, and harmful use of alcohol.

It is important to integrate childhood diabetes into national noncommunicable disease (NCD) strategies, with clear goals for early diagnosis, treatment access, long-term management, and reducing

preventable complications. Children and adolescents should be included explicitly in policies to avoid being overlooked in adult-focused diabetes programs.

All children with diabetes, regardless of residence status, income, or disability should have guaranteed universal health coverage, timely diagnosis and treatment, and free or affordable access to insulin and diabetes medications, blood glucose monitoring devices and test strips, insulin pumps and continuous glucose monitoring (CGM) where feasible.

The management of diabetes in children is challenging and is different from that of adult diabetes. Young people with diabetes require special attention and care for managing the condition as they experience the burden of living with a chronic disease during a critical developmental phase of their lives characterized by biological, psychosocial and cognitive changes. For this reason, multidisciplinary diabetes teams comprised of specialists with expertise in both diabetes and pediatrics are crucial for supporting young persons in all aspects of diabetes management (medical, nutritional, psychological, and educational support).

Schools' staff should be trained to support children with diabetes (e.g., recognizing hypoglycemia, insulin administration) and the emergency supplies should be available. Children with diabetes should have flexible arrangements for meal times, physical activity, and health monitoring.

IV. LEGAL PROTECTION OF CHILD IN THE HEALTHCARE

Protecting children's autonomy, privacy, and confidentiality in healthcare is a critical part of respecting their human rights and fostering trust in health systems. In line with international standards such as the UN Convention on the Rights of the Child (CRC) and WHO guidelines, European healthcare systems are increasingly expected to balance children's evolving capacities with their need for protection and support.

4.1. Autonomy in decisions

Respecting children's autonomy in healthcare means recognizing their right to participate in decisions about their own health and treatment. As children develop, they gain the capacity to understand their health needs and express informed preferences. Protecting children's autonomy in healthcare is a fundamental component of upholding their rights and dignity. In line with the UN Convention on the Rights of the Child, all children have the right to express their views freely in matters affecting their health, to have those views taken seriously in accordance with their age and maturity, and to access healthcare in environments that respect their privacy and safeguard their personal information.

Healthcare systems must recognize children's evolving capacities by involving them meaningfully in decisions about their care, ensuring that services are delivered in a child-friendly manner.

Legal and policy frameworks should clearly define the rights of children to consent, refuse, or access care independently, particularly during adolescence, while also guiding health professionals on balancing child protection with respect for autonomy. Healthcare providers must receive training in ethical and child-rights-based approaches, and systems must ensure the protection of personal health data and privacy in both physical and digital health environments.

Healthcare professionals have a responsibility to involve children meaningfully, ensuring they are listened to and supported in making choices appropriate to their age and maturity. Healthcare professionals are encouraged to engage children in discussions about their care and treatment options in a way they can understand. It is important to consider the child's views, values, and emotional readiness, especially in situations involving long-term care, mental health, or chronic illness. Adolescents should be offered greater independence in making decisions, while maintaining necessary guidance and protection. Parental involvement should be balanced with respect for the child's growing decision-making capacity.

Promoting autonomy helps children build confidence, enhances adherence to treatment, and lays the foundation for lifelong engagement with health services.

Survey results

22 of 27 jurisdictions included in the survey confirmed that they have adequate legislation for the health care system to ensure that children's rights in terms of privacy, confidentiality, and informed consent. However, 5 respondents mentioned that the legislation in this regard in their jurisdictions only "*partially*" covers these issues, indicating certain insufficiencies.

> *"There are only general obligations regarding the beneficiaries of the GHS and not specific legal obligations regarding children."*
>
> The Commissioner for Children's Rights' Office, Cyprus

At the same time, 26 out of 27 jurisdictions indicated that they have established laws or policies that guarantee children's right to participate in decisions regarding their treatment or care.

All participating jurisdictions confirmed the presence of a mechanism for children or their guardians to file complaints or report violations of healthcare rights.

For the right to health to be fully realized, the patient must be informed about the state of health, the methods of diagnosis and treatment proposed by medical workers. This should be done in a language understood by the patient. From the survey we note that informing the patient in a language understood by him is not an obligation for medical institutions in all jurisdictions included in the study. The majority, 22 jurisdictions, confirmed that they provide translation in patient communication in the medical institution.

"*The Laws on the State Language of the Republic of Lithuania and on Public Administration of the Republic of Lithuania establish that the language of administrative procedures carried out in state and municipal institutions and organizations is the state Lithuanian language. The Law on Medical Practice of the Republic of Lithuania also does not oblige doctors to know a foreign language and use it at work. Nevertheless, the Ministry of Health has approved recommendations for personal healthcare institutions regarding the availability of services for patients who speak only a foreign language. One of the recommendations is: to compile: a list of doctors who can provide personal healthcare services in English and other foreign languages (e.g., Russian, Polish, German, French), etc*."

The Ombudsperson for Children's Rights, Lithuania

However, five 5 of 27 respondents stated that the jurisdiction's legislation does not provide for the institution's obligation to inform the patient who does not speak the language, therefore this responsibility is shifted to the patient/family or certain non-governmental organizations.

"The Patients' Rights Act stipulates that the healthcare provider must inform the patient in a clear and understandable manner about his or her state of health and the proposed treatments. This implies that the information is provided in a language that the patient and his or her family understand, so that they can make well-considered decisions about the care. There are language rules for hospitals in Brussels, stating that they should provide care in both Dutch and French. However, there is no mandatory use of interpreters for other languages."

Office of the Children's Rights Commissioner, Belgium/Flanders

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"*Under the Law of Obligations Act (§ 766(1)), the healthcare provider has a duty to inform the patient. This obligation must be interpreted as a duty to make information understandable for the patient – this may mean the necessity to use simple language, age-appropriate language, showing pictures/videos etc. However, this duty does not involve an obligation to provide translation to a patient who does not speak the official language of Estonia."*

Office of the Chancellor of Justice, Child's and Youth' Rights Department, Estonia

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"There is no obligation for the healthcare institution to provide translation. Translation is often provided by civil society organization employees."

The Ombudsman for Children, Republic of Croatia

The survey determined that in the responding jurisdictions, there are different approaches to the age of the adolescent that can be considered for the acceptance of informed consent in relation to medical institutions, generally ranging from 14 to 18 years. However, a particularity is observed for all the answers. The decision of the minor/adolescent patient is considered,

resulting from several factors, such as the child's maturity and ability to understand the implications of the decision. Several respondents mentioned inconsistencies and discrepancies in domestic legislation regarding the accepted age of the adolescent to provide informed consent with reference to the medical act required to be performed.

"There is a discrepancy between the Patient Rights Protection Act and the Family Act. According to the Patient Rights Protection Act, a child under the age of 18 is excluded from deciding on a medical procedure on his or her body because the decision is made for him or her by his or her legal representatives (parents). According to the Family Act, a child who has reached the age of 16 and who, according to the assessment of a medical doctor, is mature enough to make a decision on a preventive, diagnostic or therapeutic procedure related to his or her health or treatment, has the right to independently consent to an examination, test or medical procedure, i.e. to give his or her informed consent. This means that a child who has reached the age of 16 can independently go to a family doctor, dentist, orthodontist or gynecologist for an examination, test or preventive or therapeutic procedure. These procedures must not carry risks of serious consequences for the child's mental or physical health. If such risks exist, in addition to the child's informed consent, the approval of the child's parent/legal representative is also required."

The Ombudsman for Children, Republic of Croatia

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"*In Northern Ireland, a child is defined as a person under the age of 18, although the presumed age of capacity is 16 and over. As with any patient, a young person or child may have the capacity to consent to some services or treatments but not to others. As such, healthcare providers must assess maturity and understanding individually, bearing in mind the complexity and importance of the decision to be made*."

Commissioner for Children and Young People, Northern Ireland

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"In Sweden, there is no fixed age at which children can independently make decisions about their healthcare. Instead, the law emphasizes the child's maturity and ability to understand the implications of the decision. According to the Swedish Patient Act, a child's views on healthcare should be clarified and given weight in accordance with their age and maturity. This means that as children grow older and demonstrate sufficient understanding, they are increasingly involved in decisions about their own health."

Office of the Ombudsman for Children, Sweden

In 12 jurisdictions out of 27 there are some particularities regarding decisions in certain specific conditions, such as pregnancy, HIV testing, etc.

"*In Italy there are special legal provisions regulating the decisions of minors in specific situations such as pregnancy, HIV testing and other issues related to sexual and reproductive health, protecting the autonomy of the minor, with the supervision and assistance of health care professionals and sometimes parents*."

The National Authority for Children and Adolescents, Italy

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"*Emancipated minors have the same rights as adult women. Unemancipated minors can request an abortion themselves. They must obtain the consent of one of their parents (holders of parental authority), or of their legal representative. If the under-age woman wishes to keep the abortion secret from her parent(s) or legal representative(s), she has to be accompanied throughout the procedure by a trusted adult of her own choice. The psychosocial assistance service can advise the minor on the*

choice of an adult support person. The underage woman must consult a psychosocial assistance service. Following the psychosocial consultation, the unemancipated minor must confirm in writing that she is determined to terminate her pregnancy."

The Ombudsman for Children and Adolescents, Luxembourg

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"An abortion and all related procedures can be performed on a minor without the consent of the legal guardians (Article L.2212-7 of the Public Health Code). The consent of the holders of parental authority is not required for the prescription, dispensation, or administration of contraceptives to minors (Article L.5134-1 of the Public Health Code). Family planning or education centers provide anonymous and free screening for sexually transmitted infections (STIs) for minors who request it ".

The Children's Defender, Office of the Rights Defender, France

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"In specific situations, such as reproductive health care, a minor may be considered competent to make decisions independently, without parental consent. Unless there are very strong indications that the minor cannot be considered competent, the minors may decide for themselves about contraception, pregnancy tests or HIV tests. For abortion, the law states explicitly that each woman decides for herself and that there are no age requirements (parental consent is only required if full anaesthesia is necessary in a hospital, abortion centers use local anaesthesia which does not require parental consent). There is an agreement with the RIZIV, which means that on the one hand the third-party payment scheme always applies so the patient does not have to pay out of pocket and on the other hand the procedure is not visible in the file at the health insurance fund. "

Office of the Children's Rights Commissioner, Flanders/Belgium

Policy level approach

Ensuring the autonomy of children in healthcare must be grounded in human rights principles, particularly those set out in the UN Convention on the Rights of the Child (CRC), notably Articles 12 (right to be heard) and 24 (right to health). Autonomy is not absolute in childhood but must be supported progressively according to the child's age, maturity, and evolving capacities.

It is necessary to establish clear legal standards to recognise the evolving capacity of children to participate in healthcare decisions and to define age or maturity thresholds for independent consent to specific services (e.g., sexual and reproductive health, mental health, vaccinations).

The laws should protect the right of children to express informed views, and require those views to be considered in line with the child's capacity.

It is necessary to draw up national clinical guidelines for involving children in decision-making in all areas of care, including chronic illness, surgery, mental health, and end-of-life care, that would help medical staff make correct decisions, from a legal and ethical point of view, in relation to the decision of adolescents. The health professionals need specific abilities and knowledge to assess a child's competence and involve them appropriately in medical decisions. It is appropriate to include provisions for shared decision-making models, which support both child participation and appropriate adult guidance.

By adopting a rights-based, systemic, and age-appropriate approach to child autonomy in healthcare, European health systems can deliver care that is more effective, ethical, and empowering for children and adolescents.

4.2. Privacy and confidentiality

Privacy and confidentiality are fundamental rights for children and adolescents in healthcare. They are not only legal and ethical obligations but also essential for delivering effective, respectful, and child-centred care.

Protecting the confidentiality of children and adolescents in healthcare is essential for building trust and ensuring access to safe, respectful care. Confidentiality encourages young people to seek help without fear of judgment or exposure. Special attention must be given to sensitive health areas — such as mental health, sexual and reproductive health, and substance use — where access to confidential advice and services is essential for promoting trust, safety, and well-being.

It is important to have a clear legal framework regarding when information can or must be shared, especially if the child is at risk of harm. Healthcare professionals should provide opportunities for private consultations, especially for adolescents, and explain confidentiality policies clearly. In the same time, health professionals should be prepared to advocate for confidentiality when systemic or cultural norms challenge this right. Upholding confidentiality respects children's dignity, encourages open communication, and contributes to more effective and equitable care.

Survey results

Respondents generally confirmed that the legislation in force in the jurisdictions they represent protects and has provisions dedicated to the privacy and confidentiality of medical information.

However, cases of inconsistency or certain gaps were also identified in the survey results that leave room for interpretation and may create the risk of violating the confidentiality of adolescents' medical information by giving access to their parents/guardians without their consent.

"Under the Law of Obligations Act (§ 766(4)), a child enjoys patient rights stipulated in subsections 1 and 3 of § 766 (the right to receive information and the right to give or refuse consent) insofar as the child is able to consider responsibly all the arguments for and against (hereinafter "ability to reason"). This means that if a child comes to a doctor's appointment and does not wish to entrust the parents with the concerns the child has, and if the doctor concludes that the child is capable of considering responsibly the details of resolving a specific health problem then the doctor must proceed from the child's decision. There is no age limit given by the law, the healthcare provider decides based on the competence of a given child, regardless of the child's age. However, there are some practical problems with enforcing a competent child's right to privacy. A child with the ability to reason (see above provisions) is entitled to keep their health data to themselves. This means that they may even protect their data from their parents or other legal guardians. Currently the e-health system lacks a technical solution to enable the doctor to block the data for the child's parents even though the young person may be competent in doctor's opinion."

Office of the Chancellor of Justice, Child's and Youth Rights Department, Estonia

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When the child is over 16 years old, healthcare personnel are, as a general rule, bound by confidentiality towards the parents, unless the child consents to the information being shared. The child may consent and grant authorisation for one or both parents to access medical records on the child's behalf. However, information necessary to fulfil parental responsibilities must still be provided when the patient is under 18 years old. The patient must be informed that the information is being shared. Parents should be provided with information and access to details about the child's health and healthcare that is necessary to fulfil parental responsibilities when the child is under 18 years old. Healthcare personnel have a duty to inform the parents. This particularly applies to information about

serious mental health disorders, risk of self-harm or developmental delays, use of illegal substances, or significant physical injuries due to criminal actions. The information should be limited to what is necessary to uphold parental responsibilities and generally does not include a full account of the health condition and healthcare. It may be necessary to document that such information has been provided. However, it must be assessed whether information necessary to fulfil parental responsibilities should be shared through digital access, or if the information should be provided in another manner, such as through direct contact. The patient should be informed that such information has been shared."

The Ombudsman for Children, Norway

Policy level approach

Protecting the confidentiality of adolescents in healthcare is essential for creating trust, ensuring access to sensitive health services, and upholding adolescents' rights to privacy and dignity. This approach must be rooted in international standards such as the UN Convention on the Rights of the Child (CRC), particularly Articles 12 and 16, and should align with national legal frameworks, public health priorities, and ethical clinical practice. Healthcare systems must ensure that all children, especially adolescents, have access to confidential consultations, clear information about their rights, and safeguards that protect their personal data. Child's right to privacy is a cornerstone of child-centred care and a critical step toward empowering young people to take ownership of their health and well-being.

At the same time, professionals must be trained to balance confidentiality with their duty to protect children from harm, following clear ethical and legal guidance. It is important to codify adolescents' right to confidential healthcare in national legislation and health policy, especially for services related to: sexual and reproductive health (e.g., contraception, STI testing), mental health, substance use, abuse or violence disclosure.

The legal framework should clearly define the age or maturity threshold at which adolescents can access services without parental consent, using the principle of evolving capacities.

To avoid risky situations and confusion with confidentiality breaches, it is important to develop clear protocols for: managing parental involvement, documenting confidential information, situations where confidentiality may be breached (e.g., risk of serious harm) when it is absolutely necessary, and in a way that protects the adolescent's dignity and safety.

A strong policy approach ensures adolescents feel safe accessing the care they need, particularly for sensitive health concerns. It reduces barriers to care, promotes trust in the healthcare system, and helps adolescents develop confidence and autonomy in managing their health.

ANNEX 1. ENOC SURVEY CONCERNING PROTECTION AND PROMOTION OF CHILDREN'S RIGHT TO PHYSICAL HEALTH

Name of the Office (country/region) _____
Contact person _____
Contact details _____

PART I. STATISTIC OVERVIEW

1. **How has the vaccination rate changed in your jurisdiction over the last 5 years?**

   _____

2. **Is there evidence of the number of children with neurological and developmental disorders at the jurisdictional level? If so, what is the coverage rate with the necessary specific rehabilitation services at the country level?**

_____

3. **How has changed over the last 5 years the number of children who died because of:**

	2019		2020		2021		2022		2023	
	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.
3.1. road accidents										
3.2. drowning										
3.3. substance overdose										

4. **Please provide how the indicators of children's obesity and malnutrition has changed over the last 5 years in your jurisdiction.**

	2019		2020		2021		2022		2023	
	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.
4.1.malnutrition										
4.2 obesity										

5. Please provide the evolution of several indicators regarding the realization of sexual and reproductive rights of adolescents in your jurisdiction.

	2019		2020		2021		2022		2023	
	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.	Abs. figures	per 100 000 inhab.
5.1. abortion rate among - **10 to 14-year-olds** minors										
5.2. abortion rate among - **15 to 19-year-olds**										
5.3. incidence of sexually transmitted diseases										
5.4. adolescent maternal mortality										

PART II. HEALTH PROMOTION AND PREVENTION

POLICY DOCUMENTS - Children's health as a priority in policy documents

6. Is there a national/regional policy document (program, strategy, etc.) that directly relates to ensuring the protection of children's health?

□ There is a separate policy document dedicated to child health protection at the jurisdiction level
□ The principle of "child health in all policies" is applied in all policy documents of our jurisdiction
□ Child health is included only as part of the policy documents related to the general population health
□ The "child health in all policies" strategy is not implemented in our jurisdiction
□ Other answer: _____

7. Do you have national/regional public health programs focused on promoting children's healthy eating habits?

□ Yes □ No

If YES, please provide details _____

For example, are there any interventions or policies regarding limitation of children's access to "fast foods" that are high in fat, sugar or salt, energy-dense and micronutrient-poor, and drinks containing high levels of caffeine or other potentially harmful substances.

8. **How are breastfeeding (BF) practices promoted in your jurisdiction?**

	Yes	No	Partially
There is a comprehensive national policy / program on infant and young child feeding			
There is a national coordinator and a multisectoral national breastfeeding committee			
BF education sessions for pregnant women and in postnatal care			
Mass or social media campaign			
Limitation of promotion and marketing of food products that compete with breastfeeding (with monitoring mechanisms and deterrent sanctions for violators) – implementation of the provisions of the International Code of Marketing of Breast-milk Substitutes			
Legal framework for promotion of community and workplace support to mothers in relation to pregnancy and lactation (such as breastfeeding facilities in the workplace, breastfeeding breaks etc.)			
Support programs for good nutrition for pregnant and lactating women			

Please provide details or comments _____

9. **Are there programs, plans or strategies to promote physical activities among children outside school hours?**

□ Yes, this is a priority of the annual plans of the authorities, being under strict monitoring
□ There are only some activities that are carried out depending on the availability of funds
□ There are no such provisions
□ Other answer _____

9.1. If YES, please, give examples of successful programs for the promotion of physical activity among children that are running in your jurisdiction_____

10. **Are environmental factors (e.g., air quality, water pollution, climate change) considered in child health policies or programs in your jurisdiction?**

□ Yes □ No

10.1. If YES, please provide details _____

11. **Are there plans/strategies to prevent death or injury of children as a result of:** *(please tick)*

	Well-planned and financed strategic actions, with strict monitoring of implementation	Occasional, sporadic actions, insufficient funding	There are provisions in the policy documents, but no measures are taken	There are no strategic provisions and no actions in this area.
Road accidents				

Domestic trauma (safety in the home environment)				
Child drowning (unsupervised access to unsafe water pools)				
Addictions with and without substances				
Water quality and water-related diseases				

11.1. Please provide details and examples of good practices. *Please specify your country/region name.*
_____

12. What harm reduction strategies to prevent addictions with and without substances are employed in your jurisdiction?
□ General plan addressing addiction with and without substances
□ General plan only addressing addiction with substances
□ Specific plans for different problems to address: tobacco, alcohol, illegal substances, games, screens, etc.
□ There are no such strategies or plans
□ Other answer _____

12.1. Please, give examples of successful harm reduction strategies implemented in your jurisdiction. *Please specify your country/region name.* _____

13. Are there any public health programs implemented in your jurisdiction to prevent micronutrient deficiencies such as:
□ iron supplementation
□ folic acid supplementation
□ high dose vitamin A supplementation
□ iodized salt
□ other _____
□ there are no such programs

14. Are there any programs or plans to promote good quality of rest and sleep among children?
□ Yes □ No

14.1. If YES, please provide details _____

15. Give examples (if any) of good practice from your jurisdiction of an intersectoral approach to the problems of protecting children's health and promoting healthy lifestyle.
_____

Provisions regarding vaccination

16. Does your jurisdiction have a legal framework or specific legislation regarding mandatory vaccination? □ Yes □ No

16.1. If YES, please provide details _____

17. What are the main determined causes in your jurisdiction that are influencing the vaccination rates of children?

□ Low availability of necessary vaccines
□ Limited geographic access
□ Lack of qualified personnel
□ Resistance to vaccination due to cultural/religious reasons
□ Strong influence of fake news and anti-vax movement
□ It's not a problem, we have a high vaccination rate
□ Other _____

17.1. Add if you have any comments on this issue. *Please specify your country/region name.* _____

18. What interventions are being developed in your jurisdiction to maintain high vaccination rates?

	YES	NO	Partially
Free access to vaccination is ensured through a national program			
Vaccination requirements for school attendance			
Extensive and frequent information campaigns			
Community-based and parent-focused interventions			
Centralized reminder/recall			
Informational vaccine websites with interactive social media components			
No specific interventions			

18.1. Please provide details on this subject (good practices, successful interventions). *Please specify your country/region name.* _____

Health promotion and prevention in educational institutions

19. To what extent is health education part of the school curriculum?

□ There are special programs adapted to the specific age for each year of study
□ There are dedicated hours included only once in the general curriculum
□ There are no such provisions
□ Other answer _____

19.1 Please provide details or comments on this subject. *Please specify your country/region name.* _____

20. What does health education include in the curriculum at different levels of education? *(please tick)*

	pre-school	primary	secondary	High school level
Nutrition				
Physical activity				
Road security				
Addictions				
Sexual and reproductive health				
Sleep and rest				

21. Is there a "health agent" or similar figure in the schools in your jurisdiction who would be in charge of detection and prevention programs?

□ Full-time presence of a medical worker (doctor, nurse or public health specialists) in schools is mandatory
□ Part-time attendance of a medical worker in the school
□ It remains at the school administration's decision
□ There are no such provisions for schools in our jurisdiction
□ Other answer _____

21.1Do you have any comments on this subject? _____

22. Are there any normative provisions and programs in your jurisdiction to ensure accessible nutrition for children in schools?

□ School meals are fully covered by the state budget or by local authorities for all ages
□ School meals are covered by the public budget only for primary classes
□ There are public programs that only partially cover children's meals
□ Only children from vulnerable families are provided with meals from public funds
□ There are no such programs
□ Other answer _____

22.1. Please add if you have any comments on this subject. *Please specify your country/region name.*
_____

23. Is there strict monitoring of the nutritional value of the menus offered in the educational institutions?

□ The menus are strictly monitored by nutrition specialists and are approved in strict accordance with the regulations in force regarding children's nutrition
□ The menus are adjusted to the nutritional needs of children's age only in some institutions
□ The menus are composed based on the financial capabilities of the educational institutions, according to the funding they receive
□ Other answer _____

23.1. Please add if you have any comments on this subject. ***Please specify your country/region name.***
_____

PART III. HEALTH SERVICES

24. Are health services universal for children under 18 years of age in your jurisdiction?

□ YES □ NO

24.1. If NO, please specify:
What group of children is not covered?
Those not covered by general health services, how do they get health related attention?

25. Please indicate from what sources and to what extent children's health expenses are covered.

□ The public budget covers in full volume all expenses for healthcare provided to children
□ The public budget partially covers the necessary expenses for children's treatment
□ Child health services are covered only through special programs
□ Children's access to health services depends on their parents' insurance

□ Other answer _____

26. Which services are provided free of charge to children in your jurisdiction.

□ prevention and prophylaxis services, including vaccination and periodic health checks
□ hospital treatment for all illnesses
□ hospital treatment only for emergencies and life-threatening situations
□ hospital treatment is not covered by public funds
□ outpatient treatment at the family doctor
□ outpatient treatment at the pediatrician
□ outpatient treatment is not covered by public funds
□ full dental services, including prosthetics
□ only some dental services
□ dental services are not covered
Other _____

27. Providing children with free essential medicines (*those that satisfy the priority healthcare needs of the pediatric population*) and prosthetic items

	YES, fully according to needs	Partially	NO
The pediatric formulations are accessible and affordable in your jurisdiction			
The expenses for children's medications are covered by public funds			
Providing free hearing aid			
Providing glasses			
Providing wheelchairs and other items necessary for children with locomotor disabilities			

27.1. Please provide details _____

28. Are health services adjusted to the age of children?

	yes	no	partially
Do all medical specialties have pediatric specialty?			
Pediatrician services are equally accessible to the entire population of the jurisdiction			
Health monitoring and periodically check of children according to their age (neonates, up to 5 years, school age, adolescents)			

28.1. Please provide details _____

29. How is ensured the right to sexual and reproductive health (SRH) of adolescents?

	yes	no	partially
Free accessible adolescent-friendly health services in conditions of confidentiality and anonymity			
Accessible SRH services in remote rural regions			
Accessible SRH services adapted to ethnic communities			

SRH services adjusted to the needs of adolescents with disabilities			
Free access of adolescents to contraceptives			
There is a regulatory framework ensuring safe abortion services and post-abortion care, especially for adolescents			

30. Are there publicly funded programs for

	NO	YES, fully accessible	YES, but does not cover the high number of requests	YES, but are underfunded	Other
Children with locomotor disabilities requiring rehabilitation services					
Children with neurological and developmental disorders requiring rehabilitation services					
Children with incurable diseases requiring palliative care					
Children with HIV/AIDS at all levels of prevention, treatment, care and support					
Children with tuberculosis and from families with tuberculosis					
Children suffering from rare diseases					
Children with diabetes					
Children with intolerances					

30.1. Please provide details _____

31. What barriers do minors encounter when accessing health services?

- ◻ Low availability of services
- ◻ Limited geographic access
- ◻ Lack of qualified personnel
- ◻ Financial barriers
- ◻ Social barriers
- ◻ Racism/discrimination
- ◻ There are no barriers in access to health services

31.1. Please provide details _____

32. Are there specific policies to ensure equitable access to healthcare services for all children, regardless of their socio-economic background, ethnicity, or disability?

- ☐ Yes
- ☐ No
- ☐ Some Policies

Please provide details_____

33. How well do healthcare services cater to children from vulnerable groups (e.g., refugees, minorities, children with disabilities)?

☐ Excellent

☐ Good

☐ Fair

☐ Poor

33.1. Please provide details _____

PART IV. PLACE OF THE CHILD IN LEGISLATION ON HEALTH CARE

34. Does the healthcare system ensure that children's rights are respected in terms of privacy, confidentiality, and informed consent?

☐ Yes

☐ No

☐ Partially

34.1. Please provide details _____

35. Are there legal requirements regarding the obligation of healthcare workers to provide medical information to caregivers and children in a language they understand?

□ Yes, the healthcare institution must ensure that communication with the child and the family is done in a language they understand

□ The medical institution does not assume the translation, this must be provided by the family

□ Other answer _____

36. Are there laws or policies that guarantee children's right to participate in decisions regarding their treatment or care?

☐ Yes ☐ No

36.1. Please provide details _____

37. According to your legislation, at what age are children allowed to make decisions about their own health?

□ less than 16 years old

□ from 16 years old

□ from 17 years old

□ only from 18 years old

□ Other answer _____

38. Are there any particularities regarding decisions in certain specific conditions, such as pregnancy, HIV testing, etc.?

☐ Yes ☐ No

38.1. Please provide details: _____

39. Is there a mechanism in place for children or their guardians to file complaints or report violations of healthcare rights?

☐ Yes ☐ No ☐ Limited Mechanisms

39.1. Describe the available options:

_____

40. Is there an independent body or agency that monitors the implementation of children's rights in healthcare?

☐ Yes

☐ No

☐ Partially

40.1. If yes or partially, describe the role of this body:

_____

41. What are the priority areas for the work of your office in relation to ensuring children's right to health?

_____

42. Please propose three priority issues which your office advises should be addressed in ENOC's statement on children's right to physical health. _____