Report on the contextual determinants of child health policy

28 February 2017

Authors

Kinga Zdunek, Peter Schröder-Bäck, Mitch Blair, Michael Rigby

Status

Report on the contextual determinants of child health policy

Third draft

Origin

Work Package 1: Identification of Models of Children's Primary Health Care

Task 7: National Health and Policy Culture

Distribution

All members of MOCHA via WP Leaders and website

Context

This report will provide MOCHA members with an overview on the contextual determinants of child health policy in Europe

Contents

Acknowledgements

Acknowledgement is paid to the Country Agents of the MOCHA project as identified on the project website (http://www.childhealthservicemodels.eu/partners/). Their contributions ensured that the findings of this report are based on detailed and local indigenous knowledge.

Figures

Tables

1. Introduction

1.1. Child-centric perspective

Today nobody can deny the fact that children are the future of the nations as Jean-Jacques Rousseau said. Similarly, nobody can undermine the statement of Hans-Georg Gadamer who claimed that children are the most important value for humankind; they are the guarantee of development, stability, and reconstruction of society. Nowadays the awareness of children's rights is stronger than ever in history. In ancient times the child did not enjoy the full rights which were entitled to others. The position of the child varied from different cultural and socio-economical contexts of history.

Traditionally, a child yielded to its father's will. In Sparta, children were considered as the property of the state, which was supposed to take care of their physical and military development (Rosa, Matysiuk 2013). Aristotle pointed out the need for care of the intellectual and physical development of children and their health (Rosa, Matysiuk 2013). Unfortunately, those who were suffering from disabilities, who were born in an extramarital relationship or orphaned very often were condemned to wandering and poverty.

For centuries the father wielded the right of life and death. The change started with the development of Christianity. The child became an important family value, although the right to joyfulness and fun was significantly infringed by restricted religious rules. The Renaissance brought the reflection on the personality of the child and the Enlightenment attached great significance to the institutionalisation of care directed at those children who were excluded and marginalised. At the end of the 18th century, as a consequence of the French Revolution, children were given rights, and parents were obligated to look after them.

The industrial era brought new problems such as high mortality amongst children, delinquency and inhuman mothers' work conditions. Thanks to the development of charity and broad infrastructure of associations, the awareness of children's rights and status increased. The law against child labour in industry and agricultural sectors was announced then. With the first decades of the 19th century, it was stressed that children had not only a right to their own mental life but also a right to be respected by adults (Jakubiak 2000). Even though the sociological literature reports that until the 70s and 80s the child was still not considered as an independent individual (Rosa, Matysiuk, 2013). The independence movement of empowering the child's position was initiated by Abraham Maslov, Alice Miller, Aleksander Neill and Hubertus von Schoenbeck (Rosa, Matysiuk 2013) who were against child discrimination and called for the need of defining and respecting the child's health.

In the second decade of the 21st-century a child is considered as a 'value end in itself'. Nowadays 'children represent the future and ensuring their healthy growth and development ought to be a prime concern of all societies' (WHO, 2015).

Such change is the consequence of socio-cultural shifts in perceiving the child as an intrinsic rather than extrinsic value. Socio-cultural contexts built the value of and attitudes towards children, and in particular, towards their health care. Culture, considered as an internal system of norms and beliefs, ways of doing things, and the material and ideal concepts, generated by the social groups, plays a regulatory role towards behavioural aspects in changing multicultural Europe.

The goal of Work Package 1 is to identify the Models of Children's Primary Health Care in Europe taking into account the contextual determinants which influence the health policy style (WP 1, task 7 a). Health policy making and implementation does not happen in isolation but is always embedded in a broader societal context. The wide health policy environment includes both systemic and sociocultural elements. Initiatives in health policy are not only directed to the population but also driven by the population. Health policy might be made at many levels, involve different players and prioritise diversified issues (Walt, Gilson 1994). Walt & Gilson (1994) proposed a new paradigm in health policy analysis by applying a triangle framework in accordance with which the attention should be focused not only on the content of policy but also actors involved, processes affecting the development and implementation of the change and the context within which policy is created (Walt, Gilson 1994).

This approach enables deep insight into the analysis of child health care, as it is strongly determined by contextual (e.g. historical and cultural) aspects which reflect the hierarchy of values and depict the position of child health in it. The content of policy varies from country to country and together with the analysis of contextual factors is the baseline for developing the map of the current status of child healthcare in Europe. The public awareness of child issues is measured by the level of activity of actors who play the main role in the theatre of child health care. The process of policy making, which is understood as the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated (Buse, Mays, Walt 2005), is tangible proof of compatibility of children's needs, the voice of civil society and real action in child health care.

The following study is complementary to the study of Schröder-Bäck et al in WP1 task 7 on context. In that study, a framework is offered with which it can be analysed what actors from different sectors and on what different levels (international, national, regional, local) take and implement policy decisions. Also, the values that are – or should be – guiding decision makers are considered in this framework. The combination of both studies aims at offering a

comprehensive framework of comprehending context in which child health models and other policies take place and are implemented.

1.2. Aim of the study

The results presented in this report are a part of the study which aims to examine the child-centric health policy determinants taking into account strong contextual aspects in order to verify to which extent they are present in the processes and content of child health policy. The study reflects the health policy patterns in Europe from the angle of four elements: actors, context, content, and processes taking into account the strong socio-cultural background of these components.

To achieve the goal of outlining the interrelations between child health care and health policy 4 steps are being proceeded: 1) Conceptual framing of the Child Centric Paradigm, **2) Exploration of contextual determinants of child health policy**, 3) Analysis of the content of health policy from the angle of contextual determinants, 4) Analysis of the process of carrying out health policy from the angle of contextual determinants.

The following report is dedicated to the exploration of contextual determinants of child health policy.

1.3. Theoretical background

The study was inspired by a constructionist approach which states that reality is socially constructed. This means that the way the world is considered is the result of historical, social and political processes rather than a greater understanding of the reality (Green, Thorogood 2014). In accordance with the constructionist perspective, the existing objects in the world (the things observed) do not exist independently of the subject (an observer). They are even not discovered but constructed in the cognitive process. The conceptualization is of instrumental utility character (Sikora 2007, Wentland 2014).

Following the social constructionist perspective, the methodology chosen in this study builds on the constructionist approach of Kathy Charmaz (2000, 2006, 2008) which grows from positivistic grounded theory approach. Traditionally, the research process in grounded theory starts with analysis and finishes with defining hypotheses as an integrated baseline for theory development. The following analytical phases are applied: 1) collecting data, 2) conceptualising data, 3) categorising data and 4) generating hypotheses, 5) constructing theory as an integrated package of hypotheses. The classical grounded theory is using the constant comparative method which is characterised by constant comparison of developed categories, integrating categories and analysing the relationships between them, defining the scope of the theory and theory writing. Historically grounded theory approach required the reduction of the risk of pre-

conceptualisation. Glasser and Strauss (1967) demonstrated a very strict attitude towards the researcher's experiences and knowledge which might affect the purity of the theory grounded in data.

The constructionist approach by Charmaz (2006, 2008) respects the traditional research path; nevertheless the author proposes an approach which is more interactive, elastic and open for data in terms of the research process. The researcher is part of the process and analysis provokes to use multiple methods and different sources. Emerging data is the result of scientific reactiveness to analyses, comparisons, and interpretations. It also recognises the previous experience and knowledge which the researcher might have, thus it is more liberal in terms of preconceptualisation. In accordance with Charmaz (Charmaz, 2000, 2006, 2008) the reality is constructed under particular conditions and the research process emerges from interaction. This means that the researcher's positionality, as well as that of the research participants should be taken into account. In consequence, both, the researcher and researched are co-constructing the data. Charmaz claims that researchers are part of the research situation, which is affected by researchers' positions and interactions. *"Similarly, social constructionists disavow the idea that researchers can or will begin their studies without prior knowledge and theories about their topics. Rather than being a tabula rasa, constructionists advocate recognising prior knowledge and theoretical preconceptions and subjecting them to rigorous scrutiny*" (Charmaz 2008).

2. Methodology

The methodological procedure applied for this study was based on a hybrid approach linking the constructionist perspective of Charmaz and her data-driven inductive perspective with the elements of deductive coding which was based on the classification of contextual determinants of Leichter (1979) and incorporated into the research path. The mixed character of the approach was applied due to the nature of the research group and to adjust the project overall methodology. The constructionist constant comparative method was supported by elements of deductive thematic analysis which is considered rather as a tool which might be used across different methods (Boyatzis 1998, Braun & Clarke 2006). In accordance with Ryan and Bernard (2000), the thematic coding might be performed within 'major' analytic traditions such as grounded theory (Braun & Clarke 2006).

Such approach of mixed character allowed the tenets of social constructionism to be integral to the process of development generic maps and diagrams of the contextual factors of child health policy and care. The exploration of the contextual determinants of child health policy is a part of the investigation into the child-centric health policy determinants which takes into account strong contextual aspects to verify to which extent they are present in the processes and content of child health policy.

The main objective of the study was to explore the contextual determinants of child health taking into account strong socio-cultural background. To do this we aimed to identify the most influential factors or topics of public concern which have been perceived to have most shaped recent national health policy in each country. Figure 1 shows the change in the child actor over time, in terms of autonomy and decision-making, and the influences that combine to shape child health policy in primary care. For those purposes, the qualitative exploratory research with the goal of developing the generic "maps" of the contextual determinants of child health care was conducted.

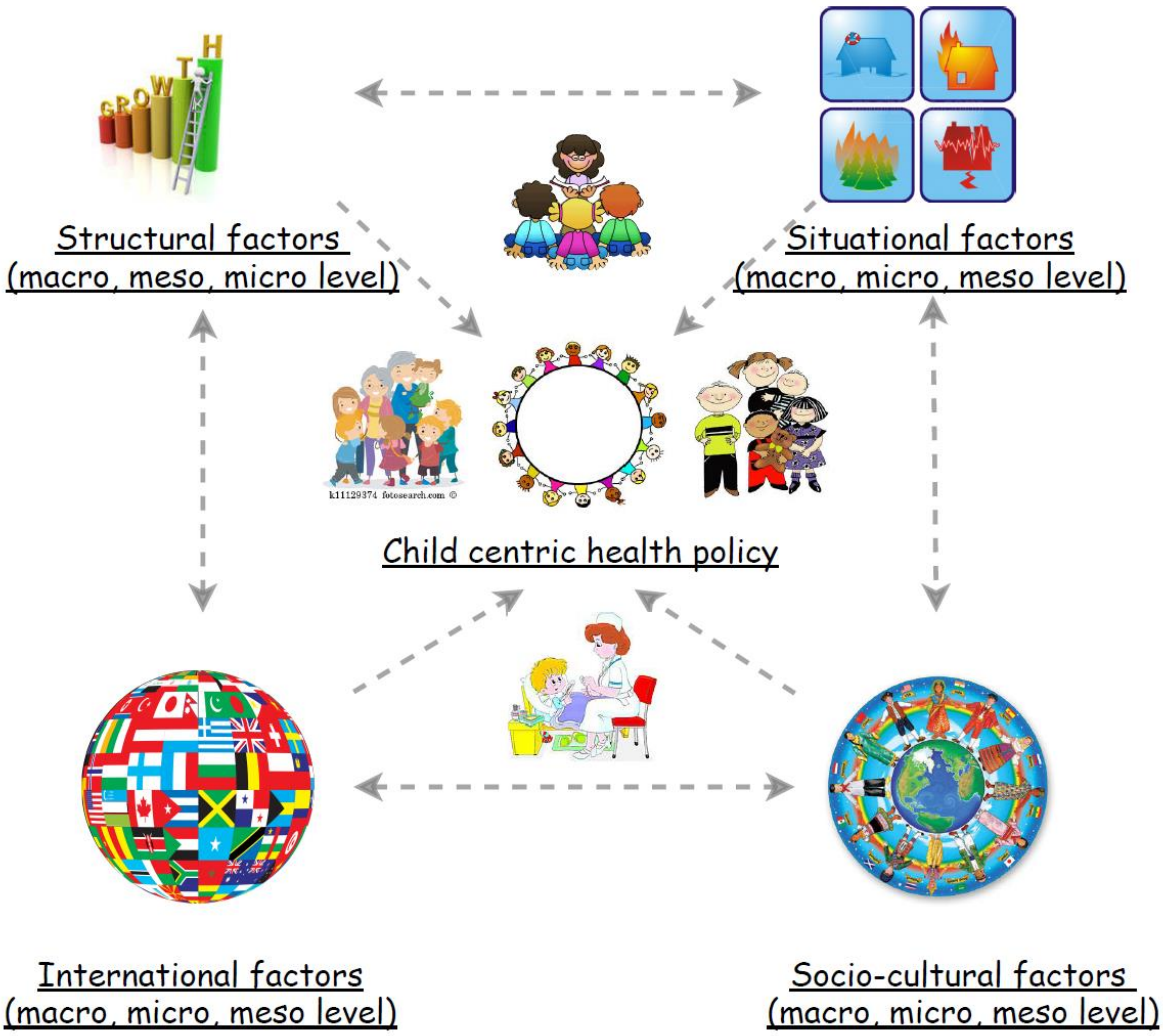

Figure 1: Child-centric health policy

In order to answer the research question**: *What are the contextual determinants of child health policy?*** Country Agents (CA) were asked to identify between 3 and 5 strong public and professional discussions related to child health services in their countries active within the last 5 years.

Country Agents in round 6 were asked to recognise the strong public and professional discussions related to child services in their countries within the last 5 years (2011-2016). However, some of the described examples, which were recently discussed in a lively manner, have been prevalent in the public concern since the beginning of the 21st century.

The questionnaire was designed as a semi-structured survey instrument and asked to describe the case, specify the object and area of public concern, indicate the broader context of the case and identify the level of discussion as well as the vehicles of public expression and the outcomes of the case[1]. The tool was distributed by the research coordinator amongst

[1] See: Appendix 1.

representatives of 30 European countries selected for their expertise and scientific experience – Country Agents.

The research stages were as follows:

- Collecting data by distributing the questionnaire to the 30 representatives of European countries through the project management office
- Pre-reviewing the data
- Incorporating the obtained data into the software for qualitative analysis NVivo 11
- Coding the data understood as the process of defining the content of the data. The coding procedure in this study indicates analysis of the material phrase by phrase in order to transform the text into codes.
- Categorising data understood as the analytical process of the certain codes selection due to their particular significance and extracting common themes and patterns identified in many codes in order to create the analytical conception and define the properties of the extracted categories.
- Constructing the schemes of the identified processes and elements.

The data collection of the issues of public concerns which affect national child health policy was carried out between 28th June and 29th July 2016 and prolonged until mid-December 2016. The representatives of 22 countries responded to the question and 65 cases characterising different areas of public concerns of European countries were described. However, the goal was not to measure quantitatively a number of cases of a particular character but to indicate the issues which across Europe may determine the way the child-centric activities are performed.

3. Case studies of current child health issues in Europe

3.1. Anti-vaccination movement across Europe

One of the greatest challenges facing Europe is the epidemic of the anti-vaccination movement. The scale of the problem varies in its intensity and the numbers of actors involved. However, it always provokes heated disputes not only within health care. In recent years the immunisation issues have been present in the public arena in most European countries. Both, supporters and opponents of voluntary vaccination concept represent robust attitudes. They put on the line arguments linked with human rights and strained trust in science in that matter and relevant authorities on one side and the public health as a public good on the other. However, it is clear that the anti-vaccination movement influences not only the individual child's health but it impacts significantly on the population behaviours and political and juridical aspects of health care organisation. The impact of opponents of the mandatory vaccination acts as a crucial contextual factor on child health care and policy at the macro level.

Estonian debate on mandatory vaccination and linking national family benefits with it was circulating around the coalition agreement which was introduced in 2015 and included a clause that proposes linking the disbursement of family benefits with periodical visits to the family physician. The initiative was supported by an Estonian family physician Marje Oona who claimed in the press that politicians should definitely consider doing so. This article started the heated debate and involved the general public in the discussion about the benefits and drawbacks of vaccination and whether deciding not to vaccinate your child should affect the payment of national family benefits. Vaccination has not been declared mandatory in Estonia, nor do parents who do not vaccinate their child receive less family benefits. However, the public discussion has not ceased.

Vaccine-hesitancy crisis in France involves politics as much as medicine, or even more. The vaccination schedule is published annually in cooperation with the Ministry of Health, following the opinion of the High Council of Public Health. However, the dispute was revived in 2015 when the petition against the commercial extinction of the trivalent vaccine DTP was issued to express the protest against bringing together the three compulsory vaccinations in France. This initiative met strong public approval as the petition has so far collected more than 1 million signatures.

The anti-vaccination movement in Italy partially has its origin in the research of Wakefield who claimed that there is the correlation between the Measles-Mumps-Rubella (MMR) vaccine and the risk of autism. Even though his results were refuted and proven wrong by scientific studies and research in the following years the conviction of its correctness constantly persists in public awareness. Anti-vaccine movements see in vaccines the cause of damage to health. The issue was raised in the public agenda in March of 2012 as the consequence of the decision of the

Court of Rimini. The judgment condemned the Ministry of Health to refund a couple of parents who had sued claiming that their son had become autistic after the administration of the trivalent vaccine justifying it partly with the results of Wakefield's report. Adverse rulings could lead to further distrust of an essential tool such as vaccinations to monitor infectious diseases and strengthen the voice of organisations and groups opposed to vaccines that promote campaigns against vaccines, urging parents not only to refuse MMR (which is optional) but also the mandatory vaccinations. In consequence, the controversy on the possible connection between vaccines and autism was reopened, even though there was already sufficient scientific proof that no correlation or causation of the MMR vaccination with autism exists

In order to control the anti-vaccination attitudes in Lithuania the former Minister Vytenis Povilas Andriukaitis issued an order that unvaccinated children will not be allowed to attend kindergartens in 2014. This policy provoked the public debate and initiated the societal movement involving actors from both proximal and distal child environments: parents, parents' representatives, NGO's and governmental institutions and individual authorities protested against this policy. Ultimately, the Constitutional Court stated that the order was against the Lithuanian Constitution, however the debate is ongoing and the problem of decreasing numbers of vaccinated children has not yet been resolved.

In Croatia, the lack of trust in the vaccine was the consequence of the certain media announcements which introduced the debate on the potential adverse effects (autoimmune disorders) of the H1N1 vaccine in 2009. In 2011 in the Medical Gazette (the Gazette of Croatian Medical Chamber) published the article regarding unnecessary risks of vaccination. Thus "there was and still is strong controversy over the vaccination of school and preschool children mandated by the Act on communicable diseases population protection (OG79/07)" (Croatian CA). The strong voice of parents supporting the change in vaccination legislation from mandatory to voluntary provoked the discussion. The anti-vaccination movement of parents was supported by the Croatian Association for Patient Rights Promotion and individual medical doctors whereas the majority of experts on the topic and medical professional organisations, e.g. Croatian Immunological Society and the Croatian Epidemiological Society, are against voluntary vaccination and the ideas proclaimed by the anti-vaccination movement and its supporters. The debate is still ongoing. "So far, the anti-vaccination movement did not manage to force changes in state laws regarding mandatory vaccination" (Croatian CA). The changes on mandatory vaccination did not appear in the currently proposed revisions of the Act on communicable diseases population protection.

Mandatory vaccination became a public issue in the Czech Republic in the year 2002. The concern was raised by Paracelsus, the association advocating freedom of choice in children's

vaccination. By reference to Charter of Fundamental Rights and Freedoms, it turned the request to support the voluntary vaccination of children and the rights of parents to refuse the mandatory vaccination without the risk of financial sanctions. In accordance with Czech legislation vaccination of children is mandatory, thus "it happened that parents who refused to have their child vaccinated were issued administrative fines, which can reach up to 10,000 Crowns (350 EUR)" (Czech Republic CA). At stake were also the issues linked with adverse effects of vaccination and issues of responsibility and financial compensation when they occur. In consequence, "vaccination remains mandatory. But the state prepares for settling claims for complications (adverse effects) of vaccination in the form of the "Compensation fund for compensation for complications of vaccination". This fund is to be financed from contribution of the sickness funds (health insurance companies) active in the Czech Republic" (Czech Republic CA).

3.2. Defending the rights of children with special needs

When concerns related to disability of the child and, a child with special needs are at stake, it always calls the public attention. The sensitivity to problems of a vulnerable child raises the intensified debate on the situation of people with disabilities or special care needs in terms of financial benefits, access to care and services in several European countries.

In Poland, the discussion provoked by parents of disabled children in order to increase the financial benefits was the example of the "angry parents" movement, as the coordinator of the protest was the mother of a disabled boy. Protesters demanded, among others, an immediate increase in attendance allowance (benefit received in cash) in the situation when they have to resign from work to care for their children, as well as the professionalization of such home care (which means that in the opinion of parents caring for disabled children should be treated as professional work). "The problem was directly correlated with lack of adequate support for people with disabilities is caused primarily by the lack of political will and the financial deficit in the Polish budget. Poor financial support makes the families where the problem of disability occurs to be at risk of poverty and social exclusion" (Polish CA). The protest and the occupancy of the building of Parliament ended with the agreement in which parents achieved the acceleration of the decision to increase attendance allowance. Additionally, the government set up a "round table" in order to solve the problem of disabled people.

Similarly in Croatia "the public concern referred to the rights of children with disabilities and their carers as defined in Croatian health and social law acts. The parents of children with disabilities protested against discriminatory, contradictory and inequitable law acts which were changed to their disadvantage" (Croatian CA). The issue was introduced in 2012 and was the common initiative of parents and non-governmental institutions such as: 'Help children with

disabilities'. "The outcomes of the case were changes to the laws and ordinances which negatively affected the rights of children with disabilities and their parents. Efforts of the non-profit organisation resulted in partial changes to the legal acts they questioned, favouring the children with disabilities and their parents. The issue is still on-going, as not all demands of the 'Help children with disabilities' organisation were met, and the organisation actively continues to pursue its demands with the goal of improving children with disabilities welfare as well as fighting any new attempts of reducing rights" (Croatian CA).

The problem in Austria refers to the lack of sufficient statistical data over the prevalence and type of chronic illness in children where it exists. However, it seems to be mainly the symptom of a bigger issue correlated with the children suffering from chronic conditions. The deeper analysis leads us to conclude that the problem of discrimination of children with a chronic condition is emerging. It was reported that in Austria there is no awareness and no supportive structure to meet the needs of these children. Additionally, the increasing number of problems concerning their kindergarten or school attendance was observed. A child with diagnosed epilepsy, diabetes, asthma or mucoviscidosis has difficulty to be accepted in kindergarten or school. It has happened that they even lose their declared place, which is justified with the lack of required resources. Parents of such children met significant difficulties in terms of organisation of daily life in kindergarten or school, but they are facing the problem of lack of qualified personnel at school who are ready to take the responsibility for the chronically ill child. Most of them are rather concerned about legal consequences in case of committing an error. The problem is more and more present in the public awareness by the parental initiatives lobbying for the protection of school children with the chronic condition. In May 2013 a petition with 12,000 signatures was submitted to the president of the Austrian parliament. In October 2014 a public initiative was founded "Gleiche Rechte für chronisch kranke Kinder" and, was proposed with 9,000 signatures to the parliament for further processing and discussion" (Austrian CA). Some non-governmental initiatives were initiated which proved the power of the 'angry parents' movement as the factor determining the progress in sick child care. Even though the problem is still present and the case is ongoing, the debate contributed to the process of shaping standardised support and increased the awareness of the problem.

The importance of children's rights was underlined in the Czech Republic when the government adopted a strategic document "National Strategy for Protection of Children's Rights". The awareness of the need of special care for vulnerable children appeared in the public domain around the year 2009 when the attempts to transform the system of care for mentally, physically of socially compromised children were initiated. Traditionally, the care for vulnerable children was strongly institutionalised. The new proposal is shifting in the direction of

integration with society. "The mainstream of public discussions was led by the Ministry of Social Affairs and Work with the participation of Ministry of Education and Ministry of Health. The role of the Ministry of social affairs lies mainly in defining age limits for placement of children into collective care facilities, the role of the Ministry of education is to assure successful inclusion of vulnerable children into the educational system and the role of Ministry of health focuses on Child and adolescent psychiatry with regard to the specifics of diagnosis and treatment for mental disorders age (2 to 18 years), including the issues of developmental psychology and family issues" (Czech Republic CA). Discussion around the system of care for vulnerable children is still ongoing, however from September 2016 "they will be included in schools and each school has a right for special pedagogue assistants to help with the educational integration" (Czech Republic CA).

In Iceland and Lithuania problems of children with special needs were publicly discussed as well. In Iceland the problem relates to the transformation of child health care services to adult healthcare services for children with complex care needs was publicly discussed. The needs of such children are not met by the state of the municipality that is responsible for social care services in Iceland. Parental dissatisfaction provoked the public debate which is still ongoing. In Lithuania, the problem is more linked to access to care. The public and political concerns were about the Child Development Centre which is the only institution where the treatment for children with developmental and behavioural disorders is provided. The problem refers to difficulty in obtaining the treatment, underfunding and political indifference to children's mental health. The trigger situation was the accident in the old building where the centre was located – the roof collapsed. It provoked the societal movement and the public debate with the strong involvement of parents and NGO's, even the president of the country. This provoked the Ministry of Health to undertake some initiatives. It was declared that the Child Development Centre will be moved to a rehabilitation centre; however the problem of lack of additional funding for adaptation of the building is at stake. The other location proposed does not include in the plans the additional place for the Centre. The case is still ongoing and there is no agreement on either clarity about the new location of the centre, whereas current conditions of the Centre functioning does not provision of a sufficient level of care.

3.3. Child abuse. Infringement of children's rights

One of the most striking issues around child care discussed in the public arena within recent years was the problem of child abuse. The controversial issues emerged with an increased intensity as the consequence of sustained muteness around it. Increasingly, the problem of child abuse is considered in terms of sexual abuse or exploitation and psychological mistreatment.

Many of these cases could be identified earlier or maybe even avoided if the societal and institutional reaction would occur previously.

The problem of so-called "blind eye" which referred to the lack of appropriate reaction of relevant authorities as they act in accordance with the conviction that "you don't see what you don't believe" was revealed in Norway. The case of public concern was that an 8-year old boy, Christopher, diagnosed with ADHD, died of child abuse in 2005. The discussion disclosed the lack of appropriate communication between responsible individuals and institutions. As a result, "the board of health supervision published a report in 2014 on the Duty of Health Care Personnel to report to Child Welfare Services, a review of knowledge from experience gained from supervision and other sources" (Norwegian CA). In accordance with the board suggestions, the health personnel's knowledge about the duty to report to child welfare services should be strengthened. It also raised the discussion about the limits of their duty of confidentiality. The case provoked the introduction of changes to the Act of criminal investigations and increased awareness of everybody's responsibility in child protection. The lower threshold for alerting child services was also announced.

In order to settle the past, around 2010 there was a surge in reports of sexual abuse of children in the previous years (1945-2010) that were in the institutionalised care of the Roman Catholic Church and the youth care system in the Netherlands. The investigation was supported by two types of committees: the Committee of Inquiry Deetman (Roman Catholic Church) and the Committee of Inquiry Samson (youth care system). "The sexual abuse had taken place in situations where minors were entrusted into the care of official institutions or organisations. The minors that were abused in the Roman Catholic Church were often going to boarding school there. The minors that were abused in youth care were especially vulnerable because they were taken out of an unsafe situation at home, only to be placed in a new unsafe situation in residential youth care or foster care" (Netherlands CA). As a consequence of extensive studies about the problem, the guidance including the mechanisms of investigations of sexual child abuse was developed.

The Netherlands was struggling also with severe cases of child abuse with the death of the child as a consequence. "Around 50 children a year die in the Netherlands as a consequence of neglect or abuse. Most of these cases are cases of neglect or abuse in the home and family setting" (Netherlands CA). It raised the debate about the roles and responsibilities of involved authorities, support in the treatment of those children, and the need for the preventive initiatives in order to avoid such incidents in future. The local government and municipalities have been responsible for child safety since 2015. There is a legal framework in place which aims to ensure that children are safe. In Norway, two systems are responsible for the guidance in

the case of suspected child abuse. The first one is Meldcode (reporting code) and Meldplicht (notification obligation). "In 2015 the new Child in Youth act came into force. In this act, the newest ideas about how to care for children and youth are incorporated. (…) This new act should also help decrease the number of children that are being abused and die as a consequence of this abuse. Since the act has just come into force there are no numbers yet about the effect on the number of abused children. And the discussion is still ongoing and will be ongoing for a lengthy period since child abuse isn't 100% preventable. At the moment the discussion about the "Meldcode", "Meldplicht" and registration of voluntary counselling is still ongoing" (Netherlands CA).

The Romanian case relates to the issue of overmedication refers to the prescription of medication for long periods, without revising the medication scheme and without demanding psychotherapy or other forms of therapy for children. The alleged abuse of psychotropic medication comes along with other abuses of children's rights. The case was revealed as the consequence of investigative journalism. The "reporters found out that 12 out of 28 children aged between 6 and 16 in the foster home Dacia, on the outskirts of a large Romanian city, Brasov, were administered narcoleptic medication for behaviour disorders, although the centre was not a special needs centre, but one for children at risk in their families, or abandoned mostly for family poverty" (Romanian CA). This provoked the National Agency for Child Protection and Adoption to act. As a resulting consequence of its formal investigation, it was "declared that 5,483 from 19,333 children from residential care (…) are getting medication for psychiatric disorders (conduct disorder, hyperactivity and attention deficit disorder). This represents 28% of the children in residential placement centres, excepting the thousands of children fostered in settings for special needs children" (Romanian CA). The report on children sedated in residential care units explained that these overmedication procedures were applied in order to maintain the appropriate compliance level. As the outcome of the case, the National Authority for Child protection launched the Association of young people in residential care. The mission of this NGO was to look after children in the residential care system and identify early and report any case of abuse or other maltreatment which affects their dignity.

Public discussion on child abuse in Croatia started when a parent witnessed child abuse by a medical nurse in one of the Croatian specialist hospitals. "The parent then shared what she had witnessed through social networks" (Croatian CA) which provoked the heated dispute, with strong media involvement. "A police investigation was conducted and forwarded to the district attorney, and the Ministry of Health also conducted its investigation. No elements of the criminal offence were found by the police and the Ministry of Health found no malpractice in the provision of care in the hospital" (Croatian CA). However, the unethical behaviour of the nurse

"displayed high level of public consciousness regarding child welfare and serves as a constant reminder to the health bodies for the need of high-quality child health" (Croatian CA).

The discussion in Croatia was rather episodically in contrary to Iceland, where child abuse has been on the agenda for about two decades. The scope of the discussion included sexual abuse, physical and psychological abuse and neglect. "Historical cases of sexual abuse of primary school children by teachers have also been highly debated and caused a general public outcry, abuse not only in boarding schools but also in public schools by teachers. Further, it is not only girls who have suffered sexual abuse but also boys, formerly not considered to be a problem" (Icelandic CA). The focus on child abuse was on the agenda within preventive child health services for a long time. Still, many of the health professionals responsible for reporting child abuse case have been reluctant to do so because of the delicate relationship with parents and carers. Even though there was no one particular case which provoked the debate, the problem of child abuse was gradually evolving as a consequence of various cases of child abuse reported in different kinds of schools across the ages. The issue is still present in public awareness and this results in the improvement of laws as a consequence of the impact on the judicial system and penalties (physical and sexual abuse) and introduction of changes in the educational structure.

A new face of child abuse has emerged in the United Kingdom (Northern Ireland) as a kind of "form of sexual abuse in which a person(s) exploits, coerces and/or manipulates a child or young person into engaging in some form of sexual activity in return for something the child needs or desires and/or for the gain of the person(s) perpetrating or facilitating the abuse" (UK CA) (definition by Safeguarding Board Northern Ireland). The problem was investigated by the police as Operation Owl, the initiative which was investigating missing persons in Northern Ireland. As a result of the investigation into missing children, "22 cases of suspected child sexual exploitation of children in care were identified" (UK CA), which was broadly discussed in the media and in the political arena.

3.4. Lifestyle changes – lifestyle challenges. Changes in behavioural patterns

In our data, phenomena's correlation with lifestyle appears as a substantial contextual driver of the child health care and policy. Lifestyle changes, which are a consequence of amongst others: exposure to passive smoking, exceeded medicalization of everyday life, and emergence of new dietary patterns, in particular, correlated with obesity, prove how the population's habits, customs, and attitudes are shaping the socially and culturally embedded health care standards in terms of care and policy. The consequences of changes in behavioural patterns have a broader institutional impact.

The example of healthy lifestyle initiatives were those which affected the public awareness in Latvia. The health promotion campaign with the aim to reduce children's exposure to passive smoking and information campaign aiming to reduce smoking amongst children and teenagers were the replies to the problem of relatively high smoking prevalence among the adult population. It was correlated with low prices of cigarettes. The initiative was undertaken in the shadow of amendments introduced to the law on tobacco products, herbal smoking products, and electronic smoking devices.

The concern about changing dietary patterns was reported by many countries, in most of the cases as a consequence of the surge in reports of obesity and overweight at national and international level. The issues correlated with nutritional habits which were reported by Country Agents might be described twofold. On the one hand there is the debate in terms of increasing the awareness about the problem of obesity (UK, Portugal, Netherlands, Austria, Mata, Iceland, Norway), on the other hand the concerns about nutrition are part of the debates related to e.g. introduction of the new legislation which limits access to unhealthy food (Poland) or emergence of new dietary habits with the ideology behind them (Italy).

In the United Kingdom "healthcare professionals have long been highlighting the impact of obesity on individuals and on the health and care system" (UK CA). As a consequence, legislation on the introduction of the sugar levy is planned. The initiative is supported by the publication of 'Childhood obesity: a plan for action'. "Across England, Scotland, and Wales more than one in five children during their first year of primary school are overweight or obese. In England, the risk of being overweight or obese increases as children progress through primary school. In Reception class, around 1 in 5 children are overweight or obese; rising to around a third of children by the time they reach age 10 or 11" (UK CA). The debate is still ongoing, however some consequences of the reaction to the negative impacts on huge numbers of obese individuals and increased costs of treatment were the initiative of government in England and introduction of a Childhood Obesity Plan. Even though it "does not fully address the problems and symptoms associated with obesity, it is one of the few international cross-government strategies aimed at tackling childhood obesity" (UK CA).

Whereas in Portugal obesity is considered a public health concern and it is recognised as a health problem, there is no controversy in society about it. However, the discussion started after the publication of an article in the American Journal of Human Biology which described the increased prevalence of overweight and obesity in 7–9-year-old Portuguese children. "This particular investigation was broadly diffused by the media, and then several other research teams began to investigate this issue" (Portuguese CA). Obesity in Portugal is the consequence of the improvement of living conditions over the last 4 decades. This allowed "families to acquire

goods that foster passive transportation (e.g. cars): furthermore, the eating habits of the population have been changing, people have left the Mediterranean diet and the consumption of hypercaloric nutrients has been increasing" (Portuguese CA). As a consequence, the National Platform Against Obesity has been launched and the National Health Department has been implemented.

In the Netherlands, the public discussion was raised in order to make a change in mentality in the Dutch population. For that purpose, the institution of JOGG (Youth at a Healthy Weight) was founded by different stakeholders from government to non-profit to profit organisations. Many different stakeholders involved in the discussion: parents and children themselves, but also relatives from the home environment and the school environment. The sources of negative patterns in relation to healthy diet were commercial parties that target children with unhealthy foods and popular television series or celebrities that promote unhealthy foods.

Although the rise in obesity has affected all population groups in Austria, "rather few influences and interventions could and can be seen by political decision makers" (Austrian CA). The ministerial initiatives such as "Healthy snacks" or National Action Plan for nutrition were introduced, "no planning and structures or finances are available to strengthen on this issue" (Austrian CA). The discussion on obesity was revealed after the limitation of time planned for sports classes within the school's program. This led the problem of obesity to being identified as a "victim of school autonomy". The issue is still on the public agenda, but some consequences have already been observed. The school approaches which were focused on improving dietary customs and physical activity were launched. Other initiatives include health programmes and initiatives such as a program based on serving healthy food and beverage in school cafeterias; the National Action Plan for healthy nutrition (2013); improved accessibility to services and facilities; legal recommendations, multicomponent school interventions; introduction of new procedures.

In Malta "childhood obesity is an issue that has been on the agenda for the past 5-10 years, 40 per cent of Maltese children being overweight or obese" (Maltese CA). The problem was emphasised in publications of WHO and HBSC study. The discussion was pushed forward by politicians supported by public health and paediatric doctors and broadly debated in the media. The strategical papers and plans were introduced to heighten attention to the issue. As a result of the public debate "framework legislation for the prevention of non-communicable diseases has been adopted. However, as yet, detailed regulations other than control of sale of food from school tuck shops remain to be implemented" (Maltese CA).

Further back than two last decades the child and adolescent obesity prevalence has been an issue of continuous public debate in Iceland. Alarming statistic led to a discussion on the reasons

for the significant increase in obesity prevalence. The issues of stabilisation of the trend were also present in the debate. Thus the discussion point has been "sugar drinks, and fast food, too little exercise, computer games, too little physical activity" (Icelandic CA). Many actors are involved in bringing attention to the problem, mainly health professionals and the media.

The controversy in Norway was related to a guideline published in 2010 which introduced the process of regularly weighing and measuring the height of children for primary preventive services, before school age and through school health services. The school nurses raised their voice claiming that the issues of their capacity for following up and for other necessary tasks with this new requirement should be considered. In 2015 the debate "was raised again after a school health nurse, after a weighing and measuring session, sent a letter to parents of a 9-year-old girl stating that her weight was above the norm, and the parents should make an appointment for a discussion of nutrition and activity" (Norwegian CA). The concern was on how to deal with children with results deviating from the normal standard. In consequence, an increased respect for procedural requirements by healthcare professionals was observed. Additionally, the care contributed to increasing the awareness of the problem of obesity.

The Polish case concerns the nutrition of children and youth in schools and kindergartens. The draft legislation assumes primarily the introduction of additional requirements (restrictions) for the sale, administration, advertising and presentation of foods in schools and care institutions. This law is intended primarily to strengthen the health of school children by limiting access to educational establishments and educational institutions to foods containing significant amounts of ingredients not recommended for their development. The changes in the nutrition of children in schools and kindergartens have been implemented since September 2015. As a consequence, the rules of selling, advertising, and promotion of food and nutrition requirements for children and young people under the caterers were introduced. The modifications, by being considered as relatively restrictive, gave rise to the controversy in public. Owners of small school shops, food producers and parents expressed their doubts. Because of so many controversies, there is still ongoing debate on the changes adopted in 2015. The new changes are likely to tone down the restrictive law.

European countries undertake societal and legal initiatives in order to improve the awareness of the importance of a healthy lifestyle as well as enhance the quality of care of the child. However, we can also observe the turn into exceeding health solicitude in accordance with strong beliefs (healthism) or encroachment of medicine in the areas which in the past were socially controlled (medicalisation).

The example of the first one was the discussion on dietary habits which took place in Italy in June 2016 when a 2 year-old-girl was admitted to the intensive care unit of the Gaslini hospital

in Genoa as a result of a strictly vegan diet of her parents. She was diagnosed as being underweight and with a lack of responsiveness and an overall slowing of movements. A few days of emergency therapy let to her the stabilisation of little Chiara's health state who was then transferred to the paediatric clinic. "Although this was not a case of neglect and abuse, the case was still reported to social workers and the whole matter could also involve the Juvenile Court" (Italian CA).

Iceland is struggling with the gradual increase in the use of methylphenidate for ADHD. "The controversy lies in if this increase in use is medicalization of normal behaviour of children or a new phenomenon in child development or a problem that has hitherto been unrecognised" (Icelandic CA). It activated the media, patient groups, in this case, parent groups as well as health professionals, teachers, parents, politicians.

The reply to medicalised care of mother and child was the initiative of the legalisation of home birth in Estonia. The idea appears in the public awareness in 2010 as the consequence of the initiative of Liisa Pakosta from Pro Patria and Res Publica Union (IRL). She decided to speed up the process after reading an article discussing the high number of home births in Estonia in 2009 despite it being illegal. The support came in 2011 from The Social Affairs Committee. "On August 1st, 2014, the regulation issued by the Minister of Social Affairs entered into force, covering the independent provision of midwifery care as well as the conditions and procedure of providing care during home births". However, "many health care professionals, as well as members of the general public, are still concerned about the possible health risks to both newborns and their mothers that home births may give rise to" (Estonian CA). The arguments which are raised in the discussion on one side refer to insufficient monitoring of the mother and child health condition, and lack of immediate medical care if needed. On the other side, it is highlighted that home births are less stressful and more natural and it de-medicalises the pregnancy as it should not be treated as an illness. "The debate reached its legislative conclusion in 2014 with the issuing of the corresponding regulation; however, the discussion about the benefits and drawbacks of home births are still discussed in different media outlets, by medical professionals and the general public" (Estonian CA).

3.5. Societal changes and children's mental health

The emergence of "Generation Z", which is characterised by usage of the Internet as the main source of knowledge, socialising through the social media, and familiar with the newest technologies, introduced the changes in behavioural patterns. The, so called, post-millennials, growing up through the great recession are, more than other generations, prone to mental health problems.

In Germany, the public debate revolved around the use of digital media. Particular attention was given to the smartphone addiction and its impact, especially on children and adolescents. "Growing acceptance and usage of digital media in daily routines and the potentially negative results of that for children and teenagers" (German CA). The discussion was provoked by academics, Professor Manfred Spitzer or Rainer Thomasius, and involved a lot of parents, media scientists, clinicians, experts. Public concern was triggered by numerous publications and reports about the impact of digital media on child health. Manfred Spitzer in his book "Digitale Demenz" (digital dementia) was arguing that "the excessive use of new digital media can have many negative results; amongst others, social relegation and depression. Spitzer seems to be the most engaged individual in the topic by far. His main argument is that digital media and electronic devices deprive us of the necessity to think for ourselves, which results in making us stupid" (German CA). Some arguments used in the discussion arose from the conviction that digital media is dangerous for children's and adolescents' health and provoke digital dementia and death of brain structures. The phenomenon was linked with the shift into a new era of automation, Industry of 4.0. Discussion is still present in public awareness.

In Portugal "the economic recession revitalised the Seaman's concept of alienation" (Portuguese CA). The problem contributed to the social concern about young people's mental health. "The HBSC reports in Portugal highlighted that mental distress was one of the most affected areas, children and adolescents feel less well, report a lower life satisfaction, more psychological and physical symptoms of distress and a lower hope in the future, and lower expectation towards the future" (Portuguese CA). Mental health problems as a consequence of the economic crisis provoked the emergence of the new phenomenon defined as "unwell being" and brought the decrease in resources to face it. Many actors were involved in the debate. The particular involvement of social institutions and media was observed. In response to the concern, the National Mental Health Plan was introduced. "Recently it was announced that at school level a few programs were established to promote mental health and wellbeing (EsCool – training for teachers; related to EEA grants e.g.)" (Portuguese CA). Schools have become involved in the provision of special care for children with mental health problems. Special attention was given to those whose parents tried to hide the situation and did not activate the social welfare support system.

Health professionals in Greece have raised the concerns about the correlation between children's mental health and crisis. The alarming data on depression and suicide rates amongst adults were published, however less attention was given to the problem of child and adolescent populations. "Mental health professionals (…) express and publish their concerns about mental health problems among children. In particular, they emphasise that the recorded number of

abused or neglected children admitted for child protection to the largest Greek paediatric hospitals has risen from 81 cases in 2011 to 170 cases in 2014" (Greek CA). Another controversy arose around the fact that "many parents who are unable to pay their own contribution to the state services have cut back or discontinued their children's treatment, including learning disabilities and autism disorders" (Greek CA). The case is still ongoing.

Latvia has been struggling with the problem of violence at school for many years. Particular attention was given to the issue of bullying and cyberbullying. In accordance with the state, police report the violence is becoming the major problem. The physical violence level at Latvian schools is increasing. The problem of cyberbullying has been recognised by actors of the proximal child environment such as teachers, parents, and pupils, as well as public health specialists. "The development of information technology and the Internet, the popularity of networking, increasing the cyberbullying prevalence". "Data show "Health Behaviour in School-aged Children (HBSC) survey" that an average 14% of Latvian 11, 13 and 15-year-old pupils at least 2-3 times in recent months have suffered from bullying and around 7% of the Latvian 11, 13 and 15-year-old pupils regularly suffer from cyberbullying" (Latvian CA). Undertaken initiatives were of an educational character and included the production of some educational films with the goal to prevent the destructive behaviours. Overall discussion involved authorities such as the Ministry of Welfare and the Ombudsman. Problem of bullying and cyber bullying became the prioritised issue. Some reports and strategies on the reduction of child aggression and violence were launched to control the problem of escalation.

3.6. Poverty in Europe, Europe in crisis. Child as a victim of economic crisis

The economic situation in Europe within recent years has worsened significantly. This is mirrored by the change in the child health status across Europe. The austerity policies required undertaking measures which directly or indirectly affected the distribution of health services within the country. The economic downturn has contributed to the increase of poverty, unemployment and inequality rates. This contributed to the deterioration of the socio-economic status of the family and, in consequence, child health and well-being. As the negative consequences of the macroeconomic processes negatively affect the biological, mental and social functioning of the child, then we can state that the child may be considered as a victim of the economic crisis.

The problem of child poverty emerged in Spain as the consequence of the financial and economic crisis of 2008. Frequent cases of malnourishment and deterioration of living conditions strongly affected child health and well-being and brought the risk of social exclusion. Particular attention was given to an increased rise in evictions due to mortgage non-payment, as

many of those evictions occurred among families with children. The discussion was centred around the lack of prompt and effective actions by government in order to protect children and families at risk of social exclusion. The public outcry was related to spending cuts on meal grants which deepen the risk of malnourishment of child in poverty, and the need to ensure the year-round access to the canteens, also during summer vacations. As a result, the "Plan for social inclusion of the Kingdom of Spain" for 2013-2016 was implemented by regional and local governments.

The social concern related to child poverty was pointed out in Portugal as well. "This topic has been discussed because it is assumed that it is an effect of the economic crisis that we are living in Portugal" (Portuguese CA). The debate was broadly discussed in the media and involved mainly the social institutions. Like in Spain, it was the consequence of an unfavourable economic situation. In order to minimise the risk of social exclusion, the educational sector responded to the crisis by opening the canteens during the school holidays.

In Malta**,** the case of child poverty "has been provoked by reports being issued regularly by EUROSTAT showing an increase in children at the risk of poverty as well as a local NGO (…) that has issued a report on poverty in Malta" (Maltase CA). The problem was highlighted on TV and in the media. The susceptibility to being at risk of poverty was correlated with single parent households. "As marriage breakdown becomes more common, divorce has been introduced and a significant number of immigrants are living in Malta, the traditional socio-cultural milieu associated with the Roman Catholic religion and the upholding of the family as a traditional value has been eroded. As a result, more and more children are living in single-parent households and these are at the highest risk of poverty" ((Maltase CA). Even though the debate is still ongoing, in 2015 for the first time a downward trend in rates of poverty overall was reported.

Socioeconomic adversity and instability in Greece linked with the financial crisis resulted in severe wage cuts and high unemployment rates. It "contributed to worsening poverty and economic inequality affecting mostly the unemployed, single parent families and non-EU migrants" (Greek CA). Alarming figures published in the UNICEF report, as well as concerns raised by teachers and parents because of fainting incidents in schools attributed to hunger, brought to the agenda the problem of food insecurity and hunger amongst school children. Criticism was directed not only at the educational system but also the political and economic situation. "Greek public schools (from kindergarten onwards) do not provide meals for students in any income bracket. Only day care centres provide school meals for children up to about 5 years of age. Once children enter kindergarten and primary school, parents either need to provide their children's lunch (even in all day schools) or students can purchase snacks from

canteens which operate within school premises and sell snacks and beverages. Legislation regulates the items sold by school canteens, but there is limited evidence of its enforcement" (Greek CA). In order to respond to the problem of food insecurity in Greece, the DIATROFI project was implemented. "The DIATROFI program is designed and implemented to serve a dual purpose. It indiscriminately provides all students of the participating schools with a daily free healthy meal and promotes healthy eating through educational activities targeting students and their families" (Greek CA). This initiative is supported by other governmental actions to address the food insecurity through schools.

The question of poverty and economic downturn in Ireland is associated with an increase in homelessness, in particular family homelessness. Amongst circumstances which contributed to the level of homelessness the following were highlighted: the unfavourable economic situation of the family, housing shortages and the associated contraction of the construction industry, availability and rising rents, the number of landlords exiting the private rental market. The concerns about children's welfare in relation to being homeless were pointing out that the emergency accommodation conditions are not appropriate space for the family as it limits the access to safe play and recreation space, and cooking facilities. It was highlighted that emergency accommodation has a negative impact on children's physical health and psychological well-being. As such, emergency accommodation may be located far away from school facilities, thus it may increase the travel expenses as well. "The current homelessness situation in Ireland can be related to the interplay between the economic recession which started in 2008, and the resultant negative impact on income, employment, and the contraction of the construction industry which contributed to the current housing shortage" (Irish CA). Outcomes from the debate about homelessness, and the government's efforts to address the issue include the establishment of a specific government department, namely, Department of Housing, Planning, Community and Local Government. It's main task was to develop sustainable solutions to the housing shortage in Ireland. Additionally, "in July 2016, the government launched its Rebuilding Ireland: Action Plan for Housing and Homelessness which aims to decrease homelessness and deliver 47,000 social homes by 2021" (Irish CA).

3.7. Provision and access to care and services

Limited access to care and services is always raising the public debate. The limitation in access to care is interpreted as the encumbrance of organisational, economic or socio-cultural character. Some countries reported limitations in access to vaccines as a consequence of the financial crisis, others the difficulty in access to highly-specialized medicines or the infrastructural problems. Interestingly, the questions of provision of some services correlated with ethical issues which could be mentioned here as well.

In Lithuania**,** each case of meningococcal infection is widely discussed by parents, public, and politicians. "Each media announcement concerning the meningococcal infection raises panic of parents or carers" (Lithuanian CA). The public concern which was raised in 2016 was the consequence of limited access to a new vaccine against meningococcus which appeared in Lithuania. Parents' dissatisfaction was supported by parents' associations and other NGOs. They started to negotiate the possibility of compensation for such a vaccine as it was very expensive. The case is still ongoing, however, some positive tendencies in the health education and, as a consequence, higher level of health awareness were observed.

In Greece the public debate circulated around the consequences of the financial crisis and its impact on the immunisation. "As the crisis has affected unemployment rates many people have lost their social security benefits. Recently a new law (4368/2016) has been passed facilitating the provision of health care in state health centres and hospitals to people who have no insurance. Nevertheless, reports highlight the problem emphasising also the need to address childhood vaccinations amongst refugee children. Reports also mention that there is a shortage of actual vaccines because of unpaid hospital debts to pharmaceutical companies" (Greek CA). The public attention was raised mainly through the media and involved many actors such as schools, pharmacists, and paediatricians. Even though the Greek population traditionally has very high childhood immunisation coverage rates the debate to what extent the crisis has affected the immunisation rates is still ongoing. The particular discussion concerns immunisation rates among disadvantaged populations. The effects of the debate included immunisation programmes by NGO's covering children from families suffering from the unfavourable socio-economic situation and plans for conducting the study to obtain the data about vaccination.

Profound discussion on access to vaccination in Spain started with the request for a unified vaccination schedule at the national level. "Ministry of Health, Social Affairs, and Equity, jointly with regional public health authorities, established a public financed nationwide "minimum childhood vaccination schedule" (MCVS) to be implemented in 2014 and financed by regional governments. MCVS resulted in the removal of pneumococcal and varicella vaccines even in those regions where it was already in the course and/or discontinuation of plans to include them in upcoming immunisation schedules. These two vaccines were restricted for groups at risk and hospital use. In spite of the vaccines product data sheet, both vaccines were neither dispensed in pharmacies nor received in primary health centres but received under hospital prescription" (Spanish CA). In Spain the tradition of unlimited access to free vaccination exists. Proposed changes brought the risk of those excluded vaccines not being affordable for some families within private health care. As a consequence of strong public reaction "in June, following

scientific associations positioning, information in mass media /social networks and petition of parents, varicella & pneumococcal vaccines were included in the routine nationwide childhood vaccination schedule 2016" (Spanish CA).

The issue of ADHD and autism spectrum disorder have been present in the public domain over recent years in Malta. The problem of significant importance referred to the public funding of medicines used to treat and control ADHD in particular: access to newer medicines e.g. methylphenidate extended release or atomoxetine, and access to special conditions for examinations/learning support assistance. The discussion involved mainly parents of children with ADHD and autism, and associations lobbying "for and safeguarding the needs and rights of children with this condition from the education, health, and social perspective" (Maltese CA). As a consequence "newer medicines have been made available on the formulary but access to them is still highly restricted. Given the initial high demand, Government was not initially fully ready to cater for the number of requests and a rush on the limited stocks available ensued. The issue has now mostly been dealt with" (Maltese CA).

The scope of provided medicines and access to particular services may be also discussed by taking into account the ethical issues. The moral aspects were the background of some discussions in France. The first concern was about contraception in adolescent girls, in particular, the access to emergency contraceptive pills. In the discussion the pharmacists also participated. The case was triggered by the examples of pharmacists who were refusing various contraceptives to minor girls and associated with the debate about "their code of ethics aiming to incorporate a chapter on a conscience clause. (…) In France, for girls from 15 years, the law guarantees free and anonymous access to contraception (and abortion), including the so-called morning-after pill. "Emergency contraception" is available anonymously and free of charge in pharmacies and family planning centres" (French CA). It is also available free of charge from the school nurse. Discussion within pharmacists was the consequence of the new Act of 17 May 2013 "Law on marriage for all". This regulation introduced the new rights for marriage in the name of equality and shared freedoms. In result, it influenced the traditional concept of family and initiated the public movement defending the religious and conservative values such as rejection of abortion and contraception. In consequence, the attempts of the pharmaceutical environment to incorporate the chapter on a conscience clause were abandoned.

The public debate around euthanasia in France was no less controversial than the previous one. The story of Vincent Humbert resulted in changes of organisational palliative care, including paediatric care. As a consequence of his request to commit assisted suicide, the question of euthanasia appeared in the public and political domain. The mother and the doctor who decided to fulfil his request were prosecuted. At the same time they "provoked an ethical and legislative

debate on the topic of euthanasia, culminating in the Act of 22 April 2005 on patients' rights and end of life. This law will be challenged secondarily as a result of other tragic cases, electoral promises of the candidate François Hollande, the opinion of the National Ethic Committee, and finally revised in 2016" (French CA).

Europe is facing one of the greatest humanitarian crises of our times. The continuing plight of refugee children brought to the public agenda the debate about the access to care for unaccompanied asylum seekers. The public debate around these issues has been initiated in the United Kingdom and Finland.

In the UK "there is concern over whether the needs of UASCs are being appropriately met by the UK government. In 2015, there were over 5,000 applications for dependent asylum seeking children aged under 18 years in the UK. The number of applications from unaccompanied children, excluding dependants, was 3,253 in 2015, a 67% increase compared with 2014 (Refugee Council, 2016)" (UK CA). The public discussion refers to the "concerns that the UK government is not doing enough to effectively care for UASCs. Although unaccompanied asylum seeking children represent a small percentage of the total number of looked-after children in the UK, there is a need to ensure services are adequately commissioned to meet the often complex health care needs of this vulnerable cohort of infants, children and young people" (UK CA). The debate was triggered by the events and images which shocked Europe, namely: the death of 3-year-old Aylan Kurdi, a Syrian boy of Kurdish ethnic background whose image made global headlines after he drowned on 2 September 2015 in the Mediterranean Sea and the harrowing videoing capturing five-year-old Omran Daqneesh in an ambulance in Syria. The debate is still ongoing. In May 2016 there were attempts to introduce a new initiative to resettle refugees, however no significant changes were introduced. The current political climate is less favourable toward immigration. The anti-immigrant sentiment within the UK, which has been aggravated since Brexit, constitutes an impediment to advocacy for greater care for unaccompanied asylum seekers.

The public concern in Finland was correlated with two questions. Firstly, how to provide the care and all required services for migrant children who came without parents or guardians. Secondly, are there any health threats for the Finnish society? The discussion involved both supporters and opponents of migration. "Regarding children, the very unwelcomed focus has been on the very few adults who claimed to be minors. Also, infectious diseases (especially tuberculosis and vaccinations) has been discussed from the point of view that the asylum seekers would cause a threat to the Finnish population" (Finnish CA). At the political level, the discussion referred to restricting immigration rather than children's health and their wellbeing. "The heated debate has been stopped after the number of asylum seekers decreased

substantially. Political discussion continues, and the current Parliament has decided to introduce much stricter rules for family reunification" (Finnish CA).

The access to care and provision of services was also debated in many countries from an infrastructural perspective. Lack of weekend access to paediatric care wards, closing the wards providing care for children or a convenient location of the hospital will be discussed in the next part of the report.

In Norway**,** a ten-month-old boy, Sebastian, died in an air ambulance, on the way to the central hospital. The remote transport was necessary as in the north-western part of the country, where he was living, the paediatric wards were closed during weekends. "Sebastian was born with heart failure" and "was treated for an RS infection three weeks earlier. On Friday afternoon his parents sought help at the emergency rooms, waited five hours for an air-ambulance, but no air-ambulance was available. The alternative was 3 hours in the car to the nearest paediatric ward. The family was in contact with the emergency care over the weekend". During "Sunday his condition worsened and the child was admitted to intensive care. No air-ambulance was available before late in the afternoon from a regional hospital. On the way to the hospital, the surveillance system in the air-ambulance failed and the little boy died" (Norwegian CA). This story raised the public attention about the limited access to paediatric wards at weekends. It was correlated with the discussion about a policy for centralisation of services to ensure a large enough volume of care to provide care with good enough quality and dependence of air-ambulance and good transport options in the more rural parts of the country. The broader perspective refers to the "conflict between the relationship and independence and responsibility between the local level hospital, hospital trust level, regional health authority level and national level" (Norwegian CA). Before 2002 hospital care was organised on the county level. Since 2002 the state took ownership and the process of restructuration of the hospital sector was initiated. The debate about services which should be offered at which hospital accompanied another case which reported difficulty in access to paediatric care in Norway**.** The public concern was initiated by "parents of premature babies at a neonatal care ward in Ålesund who started a fund-raiser for medical equipment to the ward (for retinal examination). Four months later, the regional health authorities proposed to close down the neo-natal ward for children born before the 26th week" (Norwegian CA). This decision provoked a massive reaction at the community level. The voice of the population was expressed through social media campaigns, local newspapers, and television, and street marches means the debate is still ongoing in the Norwegian public arena.

The infrastructural concerns were reported in Ireland as well. The paediatric care is provided both at the regional and national levels. "The national paediatric specialities are spread

across the three hospitals, which does result in duplication of services and resources and also results in children attending two or more hospitals depending on their clinical needs" (Irish CA). In the 2000's the government commitment was given that one national hospital for children would be built. The amalgamation of the three existing hospitals would facilitate the access to care significantly. From that time the debate has been focused on planned location for a single national children's hospital. There were two location points proposed. The first one was on the campus of a large city-centre based general hospital; the second location, supported by most of the parents, was on a 'green-field' site on the outskirts of Dublin. A lack of a compromise led to the proposal of a new site on the grounds of another large city-centre based general hospital, but with better transport links, to be more accessible for the patients. The discussion is still ongoing, even though the decision confirming the project was taken in April 2016. "The decision to co-locate the national children's hospital on the site of an inner-city general hospital remains, and it is anticipated that the hospital will open in 2020. However, opponents of the decision continue to raise their concerns and most recently, in June 2016, submitted a petition of 60,000 to the government to revoke the decision" (Irish CA).

An article published in June 2016 stating, that in accordance with the proposal of the developmental plan for 2017-2020, the paediatric services will not be provided in county hospitals in Estonia. The proposal of the Estonian Health Insurance Fund meant that the paediatric services will only be available in four major Estonian hospitals. Such a decision was made because of cost reduction purposes. This met disapproval of the Estonian Paediatric Association and the Estonian Union for Child Welfare. The latter wrote a formal inquiry to the Minister of Health and Labour expressing their concern about changes unfavourable for children. As a consequence of involvement of many competent authorities as well as media, national television and representatives of different health care institutions and associations, "later in June 2016, the Estonian Health Insurance Fund said that they were not planning on eliminating the positions of paediatric specialists from county hospitals, and that they are simply examining which services should be kept in county hospitals and which could be relocated to larger regional centres" (Estonian CA).

3.8. System functionality

A well-functioning health care system should meet the population needs and expectations. The system dysfunctionality in our interpretation is expressed by system deficiency in terms of a poorly functioning organisation in the case of emergency situations, insufficient infrastructural safety measures. On the other side a well-functioning health care system is responsive to the patient's needs. Therefore, attention should be given to the proper development of the organisational structures and the relevant workforce management.

The problem of system deficiency was reported in Romania. The reaction of the health care system to the 24 cases of serious digestive disorders occurred in children began in February 2016. "Of the total number, 19 children developed haemolytic-uraemic syndrome (HUS) and were transferred to Bucharest for dialysis, but 3 of them died. In 11 of the 19 children the etiological agent found was Enterohaemorrhagic E Coli O26: H11. Children who died were among the first who were reported ill, for them the diagnosis was slow, later the diagnosis and treatment were quicker, so the children survived. Some children arrived at the hospital with nonspecific symptoms of gastroenteritis and were treated as such. Subsequently, they showed symptoms of renal insufficiency and the suspicion of HUS was raised. Others arrived in the hospital with severe dehydration and anuria (absence of urination) and only there they started dialyses. For the first cases, the treatment with empiric antibiotics proved not to be helpful; 18 children survived, though children with severe kidney conditions need to continue dialysis and might suffer long-term consequences" (Romanian CA). The ministerial group which was appointed to investigate the origin of the problem concluded that the source of an epidemic outbreak of O26: H11 E Coli were, most likely, dairy products consumed by the patients or by their mothers. "In a small number of cases, the cause of the disease was improperly cooked food or improper age of the child for that type of food. As the source of the infection could not be proved for all the cases, and the dairy factory also brought laboratory evidence that their product was not infected, the discussion in the media pointed to the inadequate and slow procedures to look for the sources of infection" (Romanian CA). The controversy and public anger were related amongst others with the delay in identification of the etiological factors and "lack of openness in communication about the state of are regarding a cohort of severe digestive disorders in infants from multiple Romanian counties" (Romanian CA). The public sentiment was raised through the caregivers and media. The case involved the competent authorities such as the Ministry of Health, County Health Direction, the "Cantacuzino" Institute for immunology and vaccines, parents associations, even politicians. Contextually the story was related to a hysteria outbreak regarding possible association of HUS with the vaccination, which activated the anti-vaccination societal movement. Those arguments were overthrown by the Ministry of Health based on conducted investigation and literature. The case is still present in the public awareness as the source of the infection is not yet clear. The bacteriological tests conducted once more in German and Italian laboratories on the request of the dairy company showed negative results. It also provoked the increase in hospital controls in terms of nosocomial infections and controls of dairy products.

The case described above was not the only example of health care system malfunctioning in Romania. In August 2016 in one of the hospitals in Bucharest, a fire broke out in the Intensive Therapy ward for premature babies. The origin of the fire was a defective socket connected to an

air conditioner. When the fire started there was no medical staff member on the ward with premature babies. Only five out of eleven children survived this accident. They suffered from physical injuries and psychological trauma. The problem was identified as a consequence of the austerity policies of the Romanian government to combat the economic crisis. Staff shortages, poorly functioning organisation in the case of emergency situations, insufficient infrastructural safety measures were performed in the national debate. "Right after the incident the Ministry of Health allocated funds for all its 62 subordinated units to purchase and install warning systems against smoke and fire, also checked and repaired all electrical installations and air conditioners" (Romanian CA). The strict safety measures were applied in the hospital where the tragedy happened.

The good health care system functioning covers also the workforce issues. In Poland**,** the strike of nurses demanding higher wages and improved working conditions paralysed the functioning of the largest specialist children's hospital in Poland. The strike was associated with the suspension of patient care. At some stage of the strike, the decision about closing some hospital wards was taken. The case provoked strong social commotion. It provoked a large discussion in the media about whether nurses should use this form of strike. Some parents of sick children, as well as the politicians of the ruling party, pointed out that the resignation of patient care and the closing of some wards can be harmful to health and lives of patients. The opposite part of the dispute claimed that such a decision does not affect negatively the health of patients and was taken as a last resort in so far unsuccessful negotiations with the management of the hospital (before the nurses decided to not carry out their professional activities they protested in the form of e.g. wearing black t-shirts, ribbons, organizing hunger strikes). The strike finished after 16 days with the agreement signed by the management of the hospital and nurses from the Child Health Centre. Both sides have agreed on mechanisms which allow to a gradual implementation of the demands and working conditions. "*The agreement involves not only the end of the strike but the suspension of a dispute with the management of the hospital by the end of 2016 which lasted from December 2014"* (Polish CA). However, the debate on working conditions of nurses has not been actually ended. The problem of inadequate wages refers to the whole community nurses in Poland and requires a more holistic and systemic approach.

When the change of the system of postgraduate education in the Czech Republic was proposed by the Ministry of Health, the whole system of care for children and adolescents became the matter of public discussion. In accordance with the vision of the ministry, the specialisation exam and profession of practical medicine for children and adolescents should be abolished. "The historically functioning care based on collaboration between the profession of GPs for children and adolescents (the so-called PLGG) and Paediatricians (either hospital-based

or speciality private based) was questioned on the level of the Ministry of Health" (Czech Republic CA). The main purposes of such a decision were: the decline of the number of young healthcare providers who are specialised in child and adolescent care and the need for harmonisation of the structure of the medical education with other countries of the European Union. As a result, the specialisation of „General practitioners for children and adolescents" is not included in the newly proposed list of 33 specialisations. The case met strong disapproval of the Association of GPs for Children and Adolescents and evolved into the controversial debate in the mass-media. "PLDD (General practitioner for children and adolescents) is unique to the Czech Republic. Ongoing efforts of paediatricians to merge into the discipline of child medicine and resistance of PLDDs underpinned by the fact of so far existing differences in training and preparation for functioning as PLDDs. So far existing "uniqueness of this field of specialisation" prevents the migration of physicians in this field. The rivalry between disciplines of PLDD and Paediatrics (child medicine) for long-time employment of paediatricians in hospitals" (Czech Republic CA). However, in February 2016 the Government of the Czech Republic approved a draft law on qualification for the medical professions of doctors, dentists, and pharmacists. The bill will be discussed by the Parliament of the Czech Republic. The concern is still present in the public debate. "The Association of General practitioners for children and adolescents and the Professional association of General practitioners for children and adolescents of the Czech medical association of J.E. Purkyně are discussing the future of the field of primary care paediatricians and are trying to prevent its abolition" (Czech Republic CA).

The reform of the health care system was debated also in Finland. Currently operating municipalities (more than 300) which are providing health care and social care will be merged into 18 regions. All health care and social care services will be merged under the uniform structure. All citizens will be provided the possibility to choose between public, private and NGO service providers. The public reaction was the consequence of the debate on how maternity and child welfare clinics will be placed in the new system. "The main concern has been, if maternity clinics, child welfare clinics, and school health services have the same quality and quantity, if provided by services other than public. The uniform system with equal services around the country may be discontinued" (Finnish CA). Many experts have been involved in the debate, which was directly correlated with "the economic crises and the need to downsize the public health services (by €3,000 million by 2020) after the recently ended long-term recession. The counter-discussion was on saving for our future, as children are our future" (Finnish CA). Eventually, child welfare services and child healthcare services were excluded from the reform. "It is most likely that even maternal and child welfare clinics will be publicly operated in the future, but the final decisions have not been made, yet" (Finnish CA).

The reforms and changes undertaken within the health care system organisation hardly ever remain indifferent to public opinion. When the revision of eligibility criteria for Discretionary Medical Cards was conducted in Ireland, the public concern about how the State should support children with complex or long-term health care needs was raised. In 2014 the Discretionary Medical Cards were not renewed for many children with long term conditions and/or complex healthcare needs. This was the consequence of the centralisation of the process for assessing and issuing Medical Cards, which prior to 2011 was decentralised. "The centralisation of the Medical Card process was influenced by the economic recession and a need to improve efficiencies and cost-effectiveness, and also to reduce excess spending. This provoked the public debate which provoked "calls from parents' representative groups and the general public for the government to intervene". "The debate focused on the rights of children to have access to healthcare and included testimonials from families about the significant costs associated with caring for a child with health needs" (Irish CA). As a result of significant public concern, in 2014 the 13,000 Discretionary Medical Cards were restored. The government proposed such a solution as an interim measure. Additionally, the government appointed the "expert panel to review the issue and to advise on the best approach to assess medical needs which would benefit most from access to services currently only available to persons with full Medical Card eligibility" (Irish CA). The Expert Group effectively reacted to the problem by publishing relevant recommendations and advocating for the establishment of a Clinical Advisory Group on Medical Card Eligibility.

One of the main points of the new Child Health Act introduced in the Netherlands in 2015 was the "transition of the governance of child and adolescent mental health care (CAMH) to the municipalities, as well as the child and adolescent social care (CASC). Previously this CAMH was specialised health care with according governance via the national health system" (Dutch CA). The problem concerned the party which was responsible for the provision of referral for children to mental health facilities. Prior to the reform, this was the responsibility of the province and after the change, it was switched to the municipality level. This results in the fact that the mental health issues were moved from medical supervision into child and adolescent social care. "All mental care for children is bundled with the other youth care at the municipalities. For children that have psychiatric problems, this is not a preferable situation and it decreases the quality of care for them" (Dutch CA). The changes in service provision in terms of child and adolescent mental health encountered strong resistance from the CAMH sector. Additionally, the problem of transfer of the medical information emerged. "The data collected in the previous system at the mental health institutions can't be transferred to the municipalities without permission of the patient or his or her parents. If that is being done without permission the professionals break their medical confidentiality" (Dutch CA). The undertaken initiatives and

the involvement of CAMH, parents and other professionals did not withdraw the changes introduced with the new Child Health Act.

In the group of indicators which allowed access to the condition of the health care system we often find those related to infant mortality. The problem of high maternal and perinatal mortality rates was reported as the issue of public concern in Latvia**.** The issue was raised by in the gynaecological environment in collaboration with specialists in antenatal and hospital care, the Ministry of Health. The information was spread through different media channels. The debate between medical professionals, public health specialists and other specialists from health care institutions, and the Ministry of Health at the national level resulted in extensive measures in order to reduce the high level of mortality rates. Within recent years important improvements and policy changes have been introduced. In 2012 the Ministry of Health announced the year of mother and child health and developed Plan for Improving Mother and Child Health for 2012-2014. This plan introduced "changes related to the prenatal diagnostics and requires additional medical examinations for pregnant women, including I trimester genetic screening and necessary tests to facilitate timely diagnosing of congenital anomalies, gestational diabetes etc." (Latvian CA). Additionally, the Ministry in collaboration with representatives of specialists appointed Regular Maternal and Child Health Council meetings. Those initiatives were supplemented by new a Public Health Strategy for 2011-2017 which was developed in cooperation with WHO Europe.

In Austria**,** the new early intervention model to prevent inequality in early childhood was introduced. "Early intervention support mainly for vulnerable pregnant women, mothers as well as parents, to cope with challenges in early childhood (0-6 years). This will be achieved through the cooperation of professionals and institutions in a region and the visualisation and networking of existing offers of help" (Austrian CA). The development of the Austrian model and the establishment of the "Network "Frühe Hilfen" is not a matter of public conflict but public acceptation. "There is currently a consensus on the need and usefulness of enhanced establishment of "Frühe Hilfen" in Austria. A common understanding of "Frühe Hilfen" should be created for knowledge transfer activities and must, therefore, include all important strategic professional groups and decision makers. The further establishment of "Frühe Hilfen" should be supported by a central office for nationwide coordination, regional networking, technical support, quality development. The model "Frühe Hilfen" should be stepped up intersectoral". "Broad consensus exists that basically all families should be achieved with a special focus on families to be placed with special loads or socioeconomic disadvantages. Means, Frühe Hilfen call not exclusively, but mainly to socially disadvantaged families or families with special loads and thus make a significant contribution to health and equality of opportunity" (Austrian CA).

The pilot trials to implement the program in Austria were successful. Therefore, in accordance with the prognosis in 2016, every second Austrian region should have the Frühe Hilfen Network established.

The debate on regulation for health certification for children which was needed to attend the summer camp in Hungary took place until 2012. Such certificates should have been issued by school doctors no later than 4 days before the planned camp. The parents brought up the discussion due to the fact that schools were closed during the summer period and such a condition could not be met. The alternative solution developed by parents was using the service of the local primary caretaker or even emergency care. In some cases, parents were obligated to pay for this examination and certificate. This provoked a strong reaction of the public. "In 2012, the Association of Hungarian primary care paediatricians proclaimed, that the examination for summer camp health certificate is not a part of their tasks – but of the school doctors – as financed by the National Health Insurance Fund, therefore a fee might be charged for that by the primary care paediatrician, whenever this certificate was needed to be issued" (Hungarian CA). The intervention of the relevant Minister and Ombudsman resulted in carers' empowerment, as the child's legal representative became responsible for reporting on medical conditions of the child to attend holiday camp.

The issues linked with parents' empowerment and their right were discussed in Hungary with respect to sick pay. Parents were entitled to such payment when they were taking care of breastfed infants in the hospital and sick children up to 12 years old at home. Parents of older children were not getting sick pay which in many cases led to unethical behaviour to obtain it. "In 2013, the Association of Hungarian primary care paediatricians supported the initiative (…) named OGYEI (Országos Gyermekegészségügyi Intézet: National Institute of Child Health), currently NEFI (Nemzeti Egészségfejlesztési Intézet: National Institute for Health Development), to change the regulations concerning sick pay for parents of hospital-treated children. Finally, some entries were changed in the Act 1997. / LXXXIII. on compulsory health insurance" (Hungarian CA). The new law introduced the changes in sick pay for a parent of the hospitalised child up to 12 years old in the favour of the parent. The changes were well received and welcomed by media and parents.

In Italy**,** the outcomes of the health care system functioning were infringed by the functioning of other systems and even organised crime. The case of public concern was the environmental problem which affected the status of health in the Campana Region. This large area in southern Italy is strongly contaminated by the presence of toxic waste and numerous burnings of waste. It is called the "land of fires" and comprises an area of 1,076 km^2, where 57 municipalities are located, with nearly 2 million and a half inhabitants" (Italian CA). In this area

"the piles of waste, illegally dumped in the countryside or by the roadside, are set on fire whose smoke spreads toxic substances (including dioxin) in the atmosphere and surrounding lands. The dioxin pollution of lands is extremely dangerous because it introduces toxic substances in the food chain of animals and can even reach humans, causing an increased risk of cancer" (Italian CA). The problem of illegal activity of disposal of toxic waste was highlighted by the State Police investigation in the report in 1996. The term "land of fires" was broadly discussed in the media. It became famous worldwide thanks to Roberto Saviano and his book "Gomorra". The health care system had to react to this. The Ministry of Health undertook relevant prevention steps. "In the implementation of a specific article of law 6 of 6 February 2014 concerning the Land of Fires, the National Institute of Health had conducted an assessment related to mortality data (2005-2011) and hospitalisation (2005-2011) in 55 municipalities in the provinces of Naples and Caserta. In 17 of these municipalities, included in the Cancer Registry of the "Naples 3 South" Local Health Unit, it was also possible to study the incidence of oncological diseases. In July 2014, the data was made available on the website of the Higher Institute of Health, and in September 2015 they were published in the series of ISTISAN Reports" (Italian CA).

4. Contextual categories of child health policy

4.1. Europe's concerns about child health care. Main areas

The child issues involve the public and raise the nationwide debates. Predominantly the public concerns were directly or indirectly related to child health and depicted the national overtone. They were present in the public awareness episodically, e.g. a few weeks like in the case of contraception in adolescent girls in France or even a few years when the long-term processes and conditions were at stake, e.g. vaccination in Italy or location of the national children's hospital in Ireland.

The variety of cases described by Country Agents shows that there is broad perspective in the perception of child health problems. Each example assigns primary importance to particular issues. The significant overlaps between different areas within particular cases were observed, however this enabled the emergence of the generic structure of areas of child health care and policy due to various criteria.

The data shows that Europe's concerns about the child health care are twofold. On the one hand, the attention was devoted to systemic issues (indirect patient orientation) on the other patient/child health and wellbeing (direct patient orientation). The interfaces between different child care areas were observed. The child health problems are considered via different domains within the health care system such as primary care, specialist care, emergency care and/or social care. Within those domains the two levels of activity were observed, namely prevention directed the attention to the well child embedded in the family context, broadly understood social environment context or preventive care context and intervention which place in the centre sick children with long-term illnesses and/or complex healthcare needs as shown in Table 1.

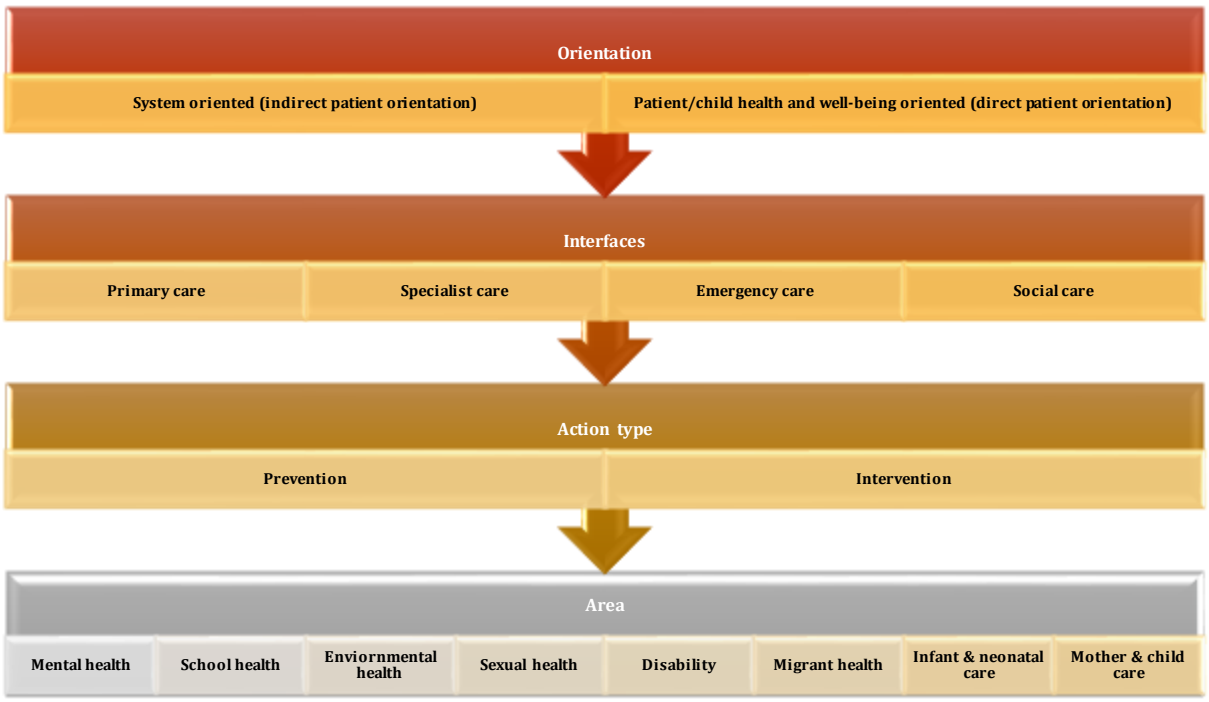

Table 1: Main areas of public concerns of child health

4.2. Placing the child at the centre in Europe. Actors of child health policy

4.2.1 Child as the central actor in the child health policy

Children are the main object (both direct and indirect) of disputes related to child health care across most of the European countries within the last decade. However, this group is not homogenous. The child as an object of the child-centric health policy is the well child (embedded in the family context, broadly understood social environment context or preventive care context) on the one side and the sick child (with long term illnesses and/or complex healthcare needs) on the other. Heterogeneity is expressed also by the differentiation of the child health issues in various age groups (from prenatal period via infancy to adolescence).

Although the child itself in most situations is not an active participant in the discussion on the shape of child health policy, as it is the subject and the cause of the societal movements we propose to call it **causative actor**, is surrounded by a proliferated network of its representatives. As these actors have a greater ability to act and represent the interest of the child they are defined as the **executive actors**. We consider them as the **agents** of the child circulating around in the proximal or distal child's environment. The proximal environment of the child is understood as the direct milieu of the child on the micro level whereas distally refers rather to indirect surrounding on the mezzo and macro level. The difference between the distal and proximal environment of the child is expressed by the type of relationship. In the proximal perspective, the agents are capable of constructing the direct relationship whereas the agents of the distal environment are rather acting on the basis of indirect contact as shown in Figure 2.

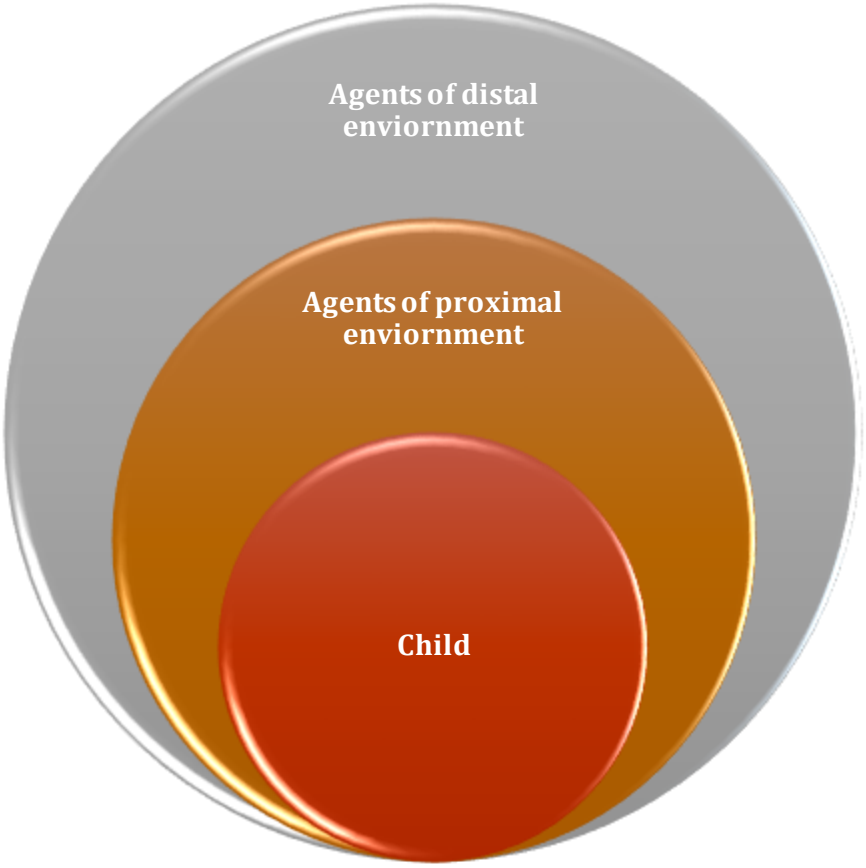

Figure 2: Child as the central actor in the process of shaping child health policy

4.2.2 The agents of the child. The children's voice representation

Agents of proximal environment

Parents are vocal in the discussions, in many situations supported by involved **caregivers** within the **social care** and **healthcare services**. They also more often than other agents are considered as both causative and executive actors.

In the Austrian case which referred to early intervention and concentrated on the "support mainly for vulnerable pregnant women, mothers as well as parents to cope with challenges in early childhood (0-6 years). This will be achieved through the cooperation of professionals and institutions in a region and the visualisation and networking of existing offers of help. So-called family companions, support families in their home environment. They guide them through the social and health system" (Austrian CA).

On the other side, parents are provoking the discussion and represent the children's voice via informally organised groups or with the support of parents associations, medical doctors or journalists. That was the case of Croatia where parents were promoting "the change in vaccination legislation from mandatory to voluntary, through publishing anti-vaccination posts on the internet, attending public protests against mandatory vaccination etc.", (….) even though "medical professional organisations, namely the Croatian Immunological Society and the

Croatian Epidemiological Society, are against voluntary vaccination and the ideas proclaimed by the anti-vaccination movement and its supporters" (Croatian CA).

A similar case was discussed in the Czech Republic where the "focus was on the rights of parents (to refuse the mandatory vaccination) without the risk of financial sanctions. Later on, as the broad spectrum of vaccination issues were discussed in public and in professional circles, the issue of "malpractice suits" for side effects (adverse effects) of vaccination became the focal point with an effort to shift the burden of such claims from the community of HC professionals who apply the vaccines (in compliance with vaccination schemes) by effort to produce a mechanism whereby parents of children who have a severe reaction to the vaccine will probably have a better chance of getting state financial compensation by means of a special fund for which compensation would be paid and not as a compensation paid by the applying physician" (Czech Republic CA).

Other people closely surrounding the child include **family members, acquaintances, friends, neighbours and school environment** as well as the **general practitioners** or other representatives of health care who are the "listeners" and "observers" institutionally empowered to act in the name of the child.

Teachers and the school environment, as the agents of the child, act based on the regular and everyday contact. Their importance was stressed in Greece where teachers as well as parents raised the issue of fainting episodes at school due to hunger. This issue "was discussed extensively in the media and the discussion concerned the need for measures to be taken by the government or other relevant stakeholders (e.g. private organisations funding such initiatives etc.)" (Greek CA). Schools were also important to partner in maintaining the problem of poverty as a consequence of the unfavourable economic situation, for example in Spain, where it was necessary "to keep school canteens open during summer vacation weekdays".(Spanish CA).

Even though the teachers are often, as mentioned above, prior listeners and observers, the case of Austria shows that there is still a lot to do to facilitate the cooperation between parents, the health care system and schools. When the child is diagnosed with "epilepsy, diabetes, asthma, or mucoviscidosis is revealed, the children are not accepted in kindergarten or school, or they lose their promised place with the declaration: we don´t have required resources (which is correct, unfortunately). Parents have to move around to find any place for their child and in most cases it is their concern to organise daily life in kindergarten or school. Sometimes they hire a so-called mobile home nursing, but they have to pay fees, and it is not possible long term for all children who would need this support. Sometimes individual teachers with specific

experiences take the risk and care, but most of them - including the director - are worried about legal consequences in case of an error" (Austrian CA).

Agents of distal environment

Health care professionals with the healthcare system in the background. The active position in the discussions, which were involving directly or indirectly the child health issues, was undertaken by the broad representation of the health care system, both the health professionals and the institutions operating within it.

The institutional voice of the health care system in the discussion on child health issues was represented by professional chambers, health inspectorates, health organisations, children's health centres and national agencies and public health institutions. The associations of paediatricians were actively involved in the discussion on vaccination and crisis-related problems (Spanish cases on unifying different regional immunizations schemes into a nationwide schedule and on child poverty and its impact on the child's wellbeing), and the Hungarian initiatives in the discussion on issuing health certificates for children who wanted to attend summer camps and the eligibility for sick pay for parents. The association for school health nurses was a party to the case of discussion about regularly weighing and measuring the height of children for primary preventive services in order to prevent obesity (Norwegian case of obesity prevention). The strong disapproval was also expressed by the Estonian Paediatric Association on the "development plan proposal of the Estonian Health Insurance Fund for 2017-2020, which does not include the provision of paediatric services in county hospitals for cost reduction purposes, which means that paediatric services will only be available in four major Estonian hospitals" (Estonian CA).

The professional group of nurses demanding salary increases (the Polish case of the strike of nurses in the largest children's hospital), pharmacists discussing about the conscience clause for delivering certain drugs (the French case of contraception for adolescent girls) or mental health professionals and psychologists lobbying for public policies that increase access to preventive programs and mental health care (the Portuguese case of mental health in young people) represented the voice of the professional groups in the processes of reorganizing the services provision and policy priorities.

Hospitals and universities involved in the debate about the location of the national children's hospital in Ireland were actively involved in planning and designing the new facility and planning and designing the education and research facilities within it.

Non-governmental sector and society. The civic organisations are concerned for the life and health of children. Non-governmental organisations in many cases are the platform for

the exchange of common views for representatives of health professionals, parents and carers and other interested persons who wish to ensure that the child health and well-being is protected. Many of them were involved in the discussion about the location of the National Children's Hospital in Dublin (the Irish case) with the goal of raising awareness and public discussion about the location of the children's hospital as well as lobbying the government to revoke the decision for the current site of the hospital. Charitable foundations providing home nursing for children with complex healthcare needs (the Irish case of the location of the National Children's Hospital) and the religious organizations which "have been involved in projects aiming to address food insecurity, collecting and offering food to people in need" (Greek CA) are examples of a genuine commitment to meeting the needs of children in an unfavourable situation. In the UK, charities and organisations have expressed outcry over the absence of a coordinated response to meet the needs of unaccompanied asylum seeking children representing and expressing their needs publicly (the UK case of asylum seeking children's needs). NGO's often were the origin of societal movements and the driver of change. The example of such is the self-help group "lobby4kids" which aims "to support individually every child/family and to advocate generally in political fields, to report the problems in the media and for decision makers" (Austrian CA).

Society as the final recipient of the decisions made in the consequence of undertaken discussions actively participates in the public debates. The dispute on immunization provoked the involvement of a broad group of experts but also a wide range of public in the Czech Republic (mentioned above) or Estonia where the general public, replying to the proposal of linking the disbursement of family benefits with periodical visits to the family physician and the article of physician Marje Oona who claimed that politicians should definitely consider doing so, "started the discussion about the benefits and drawbacks of vaccination and whether deciding not to vaccinate your child should affect the payment of national family benefits" (Estonian CA). In Poland, when the new protective children's health measures in terms of nutrition were introduced, "*in the media there appeared some information about protests of high school students in some Polish cities on the prohibitions associated with unhealthy food. The protesters claimed that they want to decide about their diet themselves. On Facebook, there is also a nationwide petition on amendments to the law on safety of nutrition and food"* (Polish CA).

Governmental sector and national services (state). The representatives of governmental institutions such as ministries, in particular the Ministry of Health (MoH) or governments and other national institutions were the party in the discussions by being the provocateur of the debate by initiating new policies or proposing new systemic solutions like in the Czech Republic where MoH proposed to modify the system of post-gradual care for medical

doctors that does not recognize the specialization of PLDD (general practitioner for children and adolescents). On the other side, the state representatives were the recipients of public demands considered as the consequences of dissatisfaction of the public with the undertaken processes which happened in Lithuania when "associations representing parents issued a "Petition for unvaccinated admission of children to pre-schools" to the Ministry of Health and the Ministry of Education and Science. More than 5,000 people signed this petition" (Lithuanian CA). In some cases, it was observed that the governmental sectors played the role of mediator or guardian. In the Polish case of conflict between nurses and children's hospital management, MoH took the role of mediator in the negotiations, however often critically commented the attitudes and demands of nurses indicating e.g. the danger of resignation from the care of sick children, groundless financial demands and generating financial costs associated with the strike.

Not only ministries represented the voice of the state. The societal movements were also involving in the debate institutions such as continual and administrative courts, expert panels, parliament members and police especially in cases of various forms of child abuse or mandatory vaccination.

Individual authorities. Initiatives undertaken by the state were often supported by individuals acting independently like ombudsman in order to protect children's rights and health or in joint committees like Committee Deetman or Samson which were vocal in the case of child abuse in the Netherlands. The high-level state representatives such as the president, prime minister or individual politicians were vocal in the debates on vaccination (Lithuania), unaccompanied migrant children (the UK) or help for children with disabilities (Croatia). As the sensitivity on child health issues is the in public domain, representatives of the business and commercial arena did not remain indifferent. Thus in the discussion on disability in Poland, the famous actor Anna Dymna was involved who is at the same time the founder of one of the largest charities "Despite everything" in Poland, and to support the sick and the disabled is influential priest, Tadeusz Isakowicz-Zaleski, co-founder and current president of the Foundation of Brother Albert. The foundation's activities include keeping houses of residence, home day care, occupational therapy workshops, adaptive community therapeutic centres, integrative schools and kindergartens. On the other hand "there are more stakeholders that play a big role in the persistence of child obesity, such as commercial parties that target children with unhealthy foods and popular TV series or celebrities that promote unhealthy foods" (Dutch CA).

Research centres and mass media. In the background of the discussed child health issues, it was observed that the crucial role was played by the research centres as prior sources of information on discussed phenomenon. A substantial role in the discussion was played by the mass media. Their dual role was expressed by investigating and disclosing the information on

one hand and as a medium of information about the various stages of the public debate on the other. The Romanian reporters found out "that 12 out of 28 children aged between 6 and 16 in the foster home Dacia, on the outskirts of a large Romanian city, Brasov, were administered narcoleptic medication for behaviour disorders, although the centre was not a special needs centre, but one for children at risk in their families, or abandoned mostly for family poverty. The reporters found that the children in this small residential unit have recently been moved to this facility and there were often conflicts between newcomers and those who have been staying longer in the centre. Some of the children came after already having had treatment from their previous facility. The local press published the article and some national TV channels transmitted the report. Further inquiries were made, in which the director declared that the psychiatric treatment is needed in order to ease the behaviour management of the children and that the medication was prescribed by the doctors" (Romanian CA).

4.3. Contextual triggers of the child health policy changes

Health policy is not isolated from contextual reality. Actions undertaken in the area of child health care are carried out by two groups of interdependent factors that trigger the onset or exacerbation of public concerns. The first group includes those triggered by the actions of the public which we classified as societal-driven and incidental experiences which provoked incident-driven initiatives. The second consists of those which are phenomenon-driven, information-driven, procedurally/legally-driven or system-driven. The groups of categories which emerged from the collected data were thus divided into two type types of constantly interrelating factors: **human factors and non-human factors** as shown in Figure 3.

Amongst all of them, we observed the subcategories of the positive and negative triggers, understood as those which drive health policy changes into adverse health effect (negative driver) or advantageous health effect (positive driver). However, the differentiation between such is a contextual challenge as the positive/negative identification varies from the assumption and prioritised values to the individual or societal experiences.

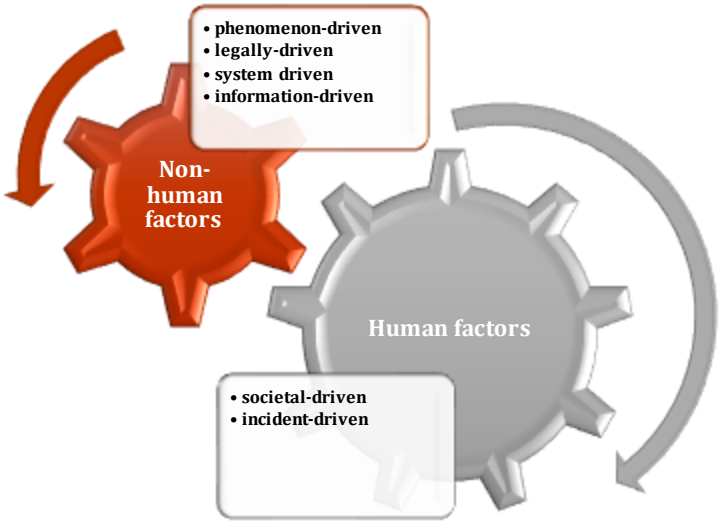

Figure 3: Interdependence of the triggers of the child health policy change

4.3.1 Human factors

Human factors which trigger the child health policy change and provoked wider social reaction were linked with **societal-driven initiatives** which were expressed by parental initiatives such as the movement of "parents to premature babies at the neonatal ward in Ålesund which started a fund-raiser for medical equipment to the ward (for retinal examination)" (Norway CA) or the petition of unsatisfied parents who expressed their stance against mandatory vaccination in the Czech Republic. The example of the "angry parents" movement was also the initiative of an Austrian mother who with other families founded the self-help group for chronically ill children "lobby4kids" (the Austrian case of discrimination of children with a chronic condition). Advocating changes in state support for children with disabilities and their caregivers in Poland was supported by the protest provoked by the parents of disabled children. Often their initiatives are supported by relevant NGO's thanks to whom the awareness of the problem is increasing (the Spanish case of child poverty and its impact on child well-being), journalists investigating and exploring undiscovered truth (the Romanian case of overmedication) or paediatricians who do not accept procedure of closed wards at the weekends (the Norwegian case of access to paediatric care in acute situations).

On the other hand, the triggering determinants of the human character might be **incident-driven,** which means that a particular situation or event provoked the public discussion and raised the concern about the problem. Often, controversies around human behaviours were of ethical character. Some discussions on the right to contraception for adolescent girls were provoked in France by the case of the "morning after pill" and the

pharmacist's conscience clause for delivering certain drugs. The case of Vincent Humbert who had written a personal, though public, letter to the president Jacques Chirac asking him to assist in a suicide that he himself could not commit, raising the question of euthanasia, was placed in the political domain (the French case of euthanasia). Italy was moved by the case of "little Chiara, a two-year-old girl admitted to the intensive care unit of the Gaslini hospital in Genoa. The child came to the hospital with a much lower weight than the average person of her age, with a lack of responsiveness and an overall slowing of movements. After a few days spent in emergency therapy, the girl is now out of danger and was transferred to the paediatric clinic" (Italian CA). The critical condition of the child was the consequence of very strict vegan diet used by the family (the Italian case of dietary customs and beliefs of parents and its impact on the child). Several countries reported cases of child abuse as the driver provoking the discussion on the responsibility for these serious violations. The incident in Croatia where a medical nurse was suspected of child abuse, the cases of child abuse in boarding schools, public schools and catholic schools in Iceland as well as the problem of child abuse with the death of the child as a consequence in the Netherlands brought an important issue into the arena of child health policy in terms of children's rights infringement. In Norway "an 8-year old boy died of child abuse in 2005. Police did not press charges before the Director of Public Prosecutions ordered the case to be investigated two years later. Christoffer's stepfather was sentenced to prison in 2008, and, after an appeal, received a prolonged sentence in 2009. The mother was charged and convicted for passive participation (this resembles the concept of criminal neglect) in 2012. (…) Christoffer had been diagnosed with ADHD, his mother referred to him being an ADHD-kid when in contact with health personnel" (Norwegian CA).

4.3.2 Non-human factors

The group of **non-human factors** that triggered societal movements towards health policy change was identified based on the emergence of 4 categories: phenomenon scale, information importance, procedural solutions and system performance.

The **phenomenon-driven** triggers prove that the large-scale processes affect significantly the child health status at the micro level and require the responsiveness at the macro level. The example of such processes which emerged from data was: the migration wave and the economic downturn as a consequence of the global crisis. The former process was associated with the problem of non-assisted asylum seekers in the UK and Finland where "the number of asylum seekers started to increase in October 2015. The public sector was not prepared, but relatively quickly reacted by providing the basic services, including healthcare services, for all of them. A special focus on the instructions was for children and children who came without a parent(s) or guardian(s)" (Finnish CA).

The latter was of particular relevance in Greece where the problem of food insecurity was broadly discussed after the reporting of fainting episodes in school children as well as in Spain where the initiatives on child poverty were conducted with the crisis in the background. The deteriorating financial condition was also the matter in Ireland where the problem of family homelessness arose.

The regulatory origin of the societal protests, triggering the child health policy changes, is correlated with the implementation of new legislation and procedures as well as the introduction of guidelines, broadly understood as **procedurally/legally-driven**. It is expressed by initiatives of the parents of children who protested against discriminatory, contradictory and inequitable law acts which were changed to their disadvantage. Such a situation happened in Croatia where the rights of children with disabilities were infringed. The modification of the system of post-gradual care for medical doctors proposed by the ministry of health that it does not recognise the specialisation of PLDD (General practitioner for children and adolescents) in the Czech Republic met with the strong response of the public as well. The problem of a lack of consensus on how to deal with children with results deviating from the normal standard defined, based on the guidelines about regularly weighing and measuring the height of children for primary preventive services, provoked the public debate in Norway. Another example triggering the public discussion was launching the development plan proposal by the Estonian Health Insurance Fund, where the clause about abolishing paediatric services from county hospitals was included. The discussion arose in June 2016 and is still a topic for debate. Similarly, the debates in the Netherlands (the case of the introduction of the Child and Youth care act) and Finland where the introduction of a possible implementation of the gender-neutral marriage legislation was discussed.

Indirectly, the procedurally-driven reaction occurred also in Ireland where changes were introduced in terms of the number of Discretionary Medical Cards which were allocated. This issue particularly came into the national spotlight in 2014 when Discretionary Medical Cards were not renewed for many children with long term conditions and/or complex healthcare needs.

This can also be seen as a trigger of systemic character, as the public concern directly arose as a consequence of the decision on allocation of Discretionary Medical Cards, but indirectly it refers to the health care system organisation and functioning. The group of **system-driven** triggers is composed of elements which demonstrate how poor organisation and infrastructure may provoke severe health risks. Lithuania was facing the "problems concerning child development center (…) for a long time due to less funding and political indifference to children's mental health, but when the roof of the very old building, where this center was

located, collapsed, parents of patients and staff of the center could not be quiet anymore. As a result, parents and non-governmental organisations appealed to the President of Lithuania Dalia Grybauskaite to help to solve this problem" (Lithuanian CA). In Romania, the fire in the intensive therapy ward for premature babies revealed the problem of service deficiency connected with the austerity policies and mobilised the public to the heated discussion on a national level. The system dysfunctionality was also disclosed when the "24 cases of serious digestive disorders occurred in children (most of them in one of Romania's 42 counties, called Arges County). Of the total number, 19 children developed haemolytic-uraemic syndrome and were transferred to Bucharest for dialysis, but 3 of them died. In 11 of the 19 children the etiological agent found was Enterohaemorrhagic E Coli O26: H11" (Romanian CA). This provoked the strong controversy in terms of medical service deficiencies, the process of the crisis management in case of an epidemic outbreak. When a new vaccine against meningococcus appeared in Lithuania, a lot of parents started to ask for it. Limited access to the vaccine caused dissatisfaction among parents and initiated the debate on the reimbursement. On the other side, the lack of trust in the competent authorities is expressed by the anti-vaccination movement advocating freedom of choice in vaccination of children. In the Czech Republic, the activity was not based on issues concerning the health of the vaccinated but as a "reaction to supposed corruption of pharmaceutical companies bribing medical doctors to vaccinate in order to increase their incomes" (Czech Republic CA). The debate around anti-vaccination in Croatia was sparked by an article regarding unnecessary risks of vaccination published in 2011 in the Medical Gazette and was a consequence of the lack of trust in the H1N1 vaccine in 2009, due to certain media announcements of alleged adverse effects (autoimmune disorders) of the vaccine.

The discussion on the vaccination and anti-vaccination movements is correlated with the next group of factors, namely **information-driven** triggers. It exposes the importance of both scientific and institutional reports as well as statistical data which provoked the discussion on the concern by disclosing the case or provision of the distressing data. In Italy, the anti-vaccination movements were associated with an article in The Lancet in 1998 "a study on twelve children who seemed to have developed marked behavioural disorders following administration of the MMR vaccine. The disputed research of Wakefield in 1998 was substantially undermined along with the reputation of the doctor in February 2004" (Italian CA). This can be identified as a direct or indirect trigger of the anti-vaccination movements in Europe and can be identified as the negative trigger.

In contrast the bulk of causes which were information-driven demonstrated rather the positive undertone. Reports from the HBSC survey started raising awareness on the issue of obesity prevalence correlated with the low proportion of time dedicated to physical education

and eating plans at school in Malta. The problem of bullying was underlined by the HSCB study in Latvia and the issue of chronic conditions in adolescents in Austria. The initiatives which were the consequence of the latter were supported by the conference at the political level as well. High perinatal and maternal mortality rates in Latvia drove the attention of the public to the problem of mother and child health care. The problem of obesity emerged in the Portuguese public arena after the publication of the article in the American Journal of Human Biology devoted to the prevalence of overweight and obesity in 7–9-year-old Portuguese children and the trends in body mass index between 1970 and 2002.

The discussion about childhood poverty in Malta has "been provoked by reports being issued regularly by EUROSTAT showing an increase in children at risk of poverty as well as a local NGO (Caritas- the local branch of Caritas international)" (Croatian CA). Locally-published data was of high relevance in other countries as well. For example, in the Netherlands where "public figures indicate that the problem of child obesity is getting bigger and bigger and needs to be addressed. In the past few years, a lot has been done to decrease obesity in children and there is some progress, but the problem is by far not yet solved" (Dutch CA). Smoking prevalence data from several country-wide studies was the trigger of the public concern in Latvia. The surge in reports about sexual abuse within the Roman Catholic Church and sexual abuse within residential youth care and foster care brought about the public discussion in the Netherlands. As a consequence of police actions and investigations, some reports were published in Italy and the UK. The reports were correlated with child sexual exploitation in Northern Ireland where the public concern was increasing as a result of a number of reports and inquiries ongoing in the public domain such as the Rochdale report and the Rotherham Report and other reports on gang and gang-related behaviour. In Italy the problem concerned illegal activity of disposal of toxic waste which provoked the dioxin pollution of lands which introduces toxic substances in the food chain of animals and can even reach humans, causing an increased risk of cancer. "The first notes about it were in the first half of the nineties by a State Police investigation (Criminalpol). The 1996 report, in which were presented the results of the investigation and the details about crimes and their alleged perpetrators, had not, however, further developments until 2011, when they restarted the investigation" (Italian CA).

4.4. The nature of contextual determinants of child health policy

The triggering determinants are understood as the situation, event or any other factor which causes the movement to begin. However, they are not the sole elements which make the machinary of change to run. The triggering factors are complemented by wider contextual situations and/or a chain of events which directly or indirectly affect the process of publicly-influenced child health policy change. The contextual determinants were grouped into four

diffusive categories of factors: socio-cultural, structural, punctual and external/international. This is shown by Figure 4.

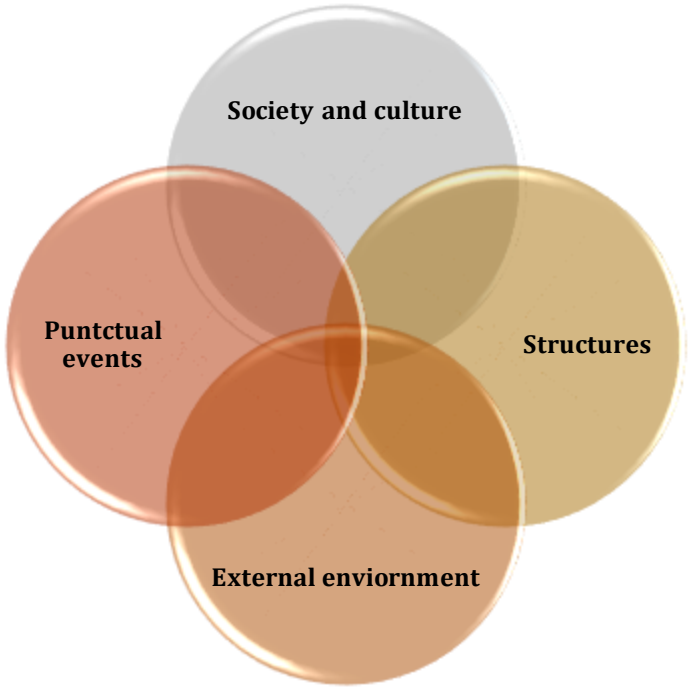

Figure 4: Interfaces between contextual determinants of child health policy

4.4.1 Socio-cultural determinants

Recognition of socio-cultural contextual elements requires admitting the change of the patient position, both at the micro and macro level. The empowerment of the child and its agents allows the identification of societal movements and activation as significant elements which determine child health policy. This entails the increased health awareness and admission of freedom of choice. Fundamental for the societal choices and behaviours are socially-recognised values, the hierarchy of values, and position of health in the hierarchy of values. This depends on various factors, for example, religion and history. The value of health is also reflected in undertaken initiatives which aim at the introduction of contextual change to the system. Often they are the reply to the shift in lifestyle trends and/or the socio-economic situation. Recognition of socio-cultural contextual elements requires admitting the change of the patient position, both at the micro and macro level. The empowerment of the child and its agents allows the identification of societal movements and activation as significant elements which determine child health policy. This entails the increased health awareness and admission of freedom of choice. Fundamental for the societal choices and behaviours are socially recognised values, the hierarchy of values, and position of health in the hierarchy of values. This depends on various factors, for example, religion and history. The value of health is also reflected in undertaken initiatives which aim at the introduction of contextual change to the system. Often they are the reply to the shift in lifestyle trends and/or the socio-economic situation.

The **societal activation** level determines the child health policy as well as care and often is driven by public sensitivity for child related issues. Activation can be of a twofold character. On one hand by activation occurrence or lack thereof. Societal activation expressed by public activism was expressed in the mass initiative advocating freedom of choice in vaccination of children in the Czech Republic. "This initiative sparked considerable controversy on the issue of vaccination. Subsequently, the public debate led also to issues related to "adverse effects" of vaccination and finally (on the level of the Czech jurisdiction) to the issue of responsibility and financial compensation for adverse effects of mandatory vaccination". "The case formed a subset issue in the decentralisation and strengthening of the patient movement in Czech healthcare" (Czech Republic CA). In Austria when the problem of a child with a chronic condition was discussed, the parents played an important role in self–management of the disease's consequences and they demonstrated the pro-activist attitudes towards the problem. However, they had to face a contrary position of the school environment where the fear against applying inappropriate procedural steps in order to provide health to the child contributed to a withdrawn attitude and a lack of adequate support for children with special needs. The origin of such behaviours was the lack of skills and awareness to meet the needs of these children.

Awareness of the problem or awareness of its impact (the Spanish case of the child poverty and its impact on its well-being) is correlated with access and availability of information (the Austrian case of a child with a chronic condition). Lack of knowledge (about the disease) was one of the determinants of vaccine rejection in France facing a crisis of vaccine hesitancy. The problem of an epidemic outbreak of 026: H11 E Coli and its potential link with vaccination in Romania "created a sort of a hysteria outbreak (…). Many parent/religious groups militated for non-vaccination after this situation, claiming a relation between vaccination of the child and symptoms of HUS. The investigation that followed showed no association, as does the literature (…). The Ministry of health gave a press declaration regarding the lack of any association between vaccination and the death of the babies" (Romanian CA). The issues of awareness may be indirectly correlated with the **communication**. The epidemic outbreak in Romania and lack of clarity in terms of informing the public about the progress and results of investigations did not contribute to the confidence growth; on the contrary, it intensified the lack of trust in the competent authorities and at the same time reinforced the social capital crisis. On the other hand, the lack of direct communication, or links of information, between hospital/health care, school and other social services in Norway reflected the passivity of the social environment to the child abuse problem and ended in the death of the 8-year old boy. The problem of so-called "blind eye" has emerged. This incident highlighted the issue of a deepening lack of **trust** expressed by decreased institutional confidence, as happens in Italy where "for several decades there have been organisations and groups opposed to vaccines that promote campaigns against

vaccines, urging parents not only to refuse MMR (which is optional) but also the mandatory vaccinations. The percentage of people in Italy vaccinated against mumps, rubella and measles decreased between 2010 and 2012 from 90.5 percent to 89.2 percent; that is about six thousand vaccinations less. Adverse rulings could lead to further distrust of an essential tool such as vaccinations to monitor infectious diseases" (Italian CA).

The national debates about vaccination often are accompanied by the issue of **freedom** expressed by respect for rights e.g. the right to refuse mandatory vaccination without the risk of financial sanctions or limited access to the services (the Czech Republic, Lithuania). The right of access to healthcare was discussed broadly in Ireland, where the problem of the revision of the eligibility criteria for Discretionary Medical Cards was at stake. "The issue provoked debate about the rights of children to have access to healthcare. It was felt that health policy which targeted children, and particularly those with long-term illnesses or complex healthcare needs, was not appropriate and was fundamentally wrong" (Irish CA).

The attitudes and beliefs not only affect the lifestyle choices at the micro level but also drive the national debates. In Finland when the case of sexual education was discussed the debate was on the political level and referred to the issues of tolerance between the liberal majority and the Christian Conservative minority. It referred in some senses to the **religion** as the phenomenon behind the undertaken initiatives. "After the acceptance of gender-neutral marriage in 2015 (in effect March 2017), some Conservative and Christian movements started to claim that sexual education should not cover information on sexual and gender minorities (…). When this did not receive practically any support, the parties opposing same-sex marriages made a citizen's proposal with more than 50,000 signatures (as required by law) to overrule the legislation on gender-neutral marriage. The main reasoning has been that it is a child's right to know their biological parents and all children have the right to a mother and a father. "The true marriage", i.e. between a man and a woman, has also been seen as a human right. The Parliament has not decided whether this counter-motion will be discussed or not" (Finnish CA).

The case with beliefs in the background was also the one which referred to the contraception for adolescent girls, in particular to the access to the emergency contraceptive pills and the discussion in the pharmacist's environment on their code of ethics aiming to incorporate a chapter on a conscience clause. The introduction of the new law on marriage for all, which was also called the Taubira law, "opened new rights for marriage, adoption, and inheritance in the name of equality and shared freedoms" (French CA). As a result, the concept of family has changed and influenced the traditional concept which was based on religious and conservative values. "This strengthened the political influence of the proponents of these values, which for many of them are also against abortion and contraception" (French CA).

Within recent years in Malta, the problem of child poverty has become an issue of public concern. The problem was diagnosed as associated with religion interwoven with tradition as it was indirectly strengthened by marriage breakdown correlated with the divorce introduction and the increasing number of immigrants living in Malta. As a result, the "traditional socio-cultural milieu associated with the Roman Catholic religion and the upholding of the family as a traditional value has been eroded. As a result, more and more children are living in single-parent households and these are at the highest risk of poverty" (Maltese CA).

Amongst the issues analysed and discussed in Europe, we observed that they reflected the contemporary socio-cultural dilemmas. Migration and the changes in the traditional family pattern brought about the emergence of discourse in terms of **tolerance**. In Finland, for example, where the sexuality education pattern has negotiated the attitudes towards homosexuals carried weight. In this discussion "children's rights have been used to oppose the gender-neutral marriage, even though the main focus has been on being against sexual and gender minorities and their rights" (Finnish CA). Finland also reported the problem of asylum seekers and raised the issue of minors who came without parents or guardians. The public discussion was for and against migration. The case referred to the provision of all the required services on one side and the potential health threats facing the Finnish society on the other. "Regarding children, the very unwelcomed focus has been on the very few adults who claimed to be minors. Also, infectious diseases (especially tuberculosis and vaccinations) have been discussed from the point of view that the asylum seekers would cause a threat to the Finnish population". "The political discussion was divided into "migrant critical" and "tolerant" crowds. In the name of free speech, even racist and xenophobic claims should be accepted" (Finnish CA). The problem of unaccompanied asylum seekers was discussed in the UK as well. "While there is a clear concern for the wellbeing of these children, the current political climate is less favourable toward immigration - captured by the anti-immigrant rhetoric spouted by pro-Brexit campaigners in the UK and the growth of far-right parties across Europe. Since Brexit, there has been an increase in the reported number of hate crimes suggesting that there is an anti-immigrant sentiment within the UK which is not positive for those who are advocating for greater care for UASCs" (UK CA).

The tradition is usually strongly embedded in the historic heritage, thus **history** was extracted as a separate category of data. As in most of these cases, the impact of the past policies and solutions, as well as inherited traditions, may be twofold. On the one side, the archaic policies correlated with the issue of child abuse which has been gradually evolving in Iceland. "Many of the historical cases have roots in a policy of taking children into custody who were deemed to fare badly in their home environment. This policy has been changed" (Iceland CA).

The historical heritage was also the determinant taken into account while the system of care for vulnerable children was built in the Czech Republic. The issue was linked to the adoption of a "National Strategy for Protection of Children's Rights - the right to a childhood," which implies the activity of "unification of conditions for the operation of services". "The case of care for vulnerable children (including family / foster family / institutional care) and inclusive education (was) strongly linked to the nationwide debate about advantages/disadvantages of the inherited "socialist-time" care, where such children were generally provided care in specialized institutions (the so-called "special schools" or "practical schools"). It also to a certain degree addresses the issue of "inclusion" of the Roma children and adolescents. The proposed change requests the change of beliefs (that compromised children are "better off" when cared for in cohorts with similar children)" (Czech Republic CA). Socialistic traditions in organising the care in residential units also affected the child care in Romania. The issue correlated with overmedication and prescription of medication for long periods, without revising the medication scheme and without demanding psychotherapy or other forms of therapy for children. "The case has historic roots, as children were in state care during the socialist period and even later, after the political shift in 1989 was neglected and abused in large residential centres. Till today, residential units for children in care are under-staffed, with existing staff badly paid, with few specialised professionals; children do not benefit from rehabilitation or therapy, even when they are diagnosed with post-traumatic stress disorder, ADHD, disabilities or other psychiatric disorders" (Romanian CA).

When the rights of children with disabilities and their carers were discussed in Croatia the parents of children with disabilities protested against discriminatory, contradictory and inequitable law acts which were changed to their disadvantage. This conflict had also strong historical correlations as the Croatian "socialist background which fosters strong social protection and is characterised by equality commitment" (Croatian CA) provoked the confrontation of the negative changes in social protection rights with parents' and carers' disapproval. The issue was especially sensitive as the children with disabilities were considered a vulnerable population group.

On the other hand, the issues correlated with the historical traditions in the organisation of child health care may be interpreted in terms of positive influence on the negotiated issue. Amongst such examples, we may point to the Spanish discussion on the establishment of the "minimum childhood vaccination schedule". This decision was accompanied by the removal of pneumococcal and varicella vaccines. "These two vaccines were restricted to groups at risk and hospital use. In spite of the vaccine product data sheet, both vaccines were neither dispensed in pharmacies nor received in primary health centres but received under hospital prescription"

(Spanish CA). The Spanish tradition of the free access to vaccines was to some extent broken. The childhood vaccination schedule is not compulsory in Spain, however vaccine products and to receive vaccines included in the immunisation schedule are both cost-free. The decision on exclusion of the vaccines from minimum childhood vaccination schedule brings the risk of deepening the hardships in access to vaccination for vulnerable groups. “A low immunisation coverage rate occurs mostly among families at risk of social exclusion and poor families, minorities and middle-class families apparently influenced by anti-vaccine individuals/groups” Spanish CA.

The attachment to the historical solutions in the healthcare organisation correlates with the discussion of the unique model of education in Czech primary care. The integral part of the system of child care in the Czech Republic was traditionally the entity of the Registering general practitioner for children and adolescents. The proposed legislative changes on medical education, where the specialisation of PLDD (General practitioner for children and adolescents) was not recognised, met the general disapproval in the medical society. “Ongoing efforts of paediatricians to merge into the discipline of child medicine and resistance of PLDDs underpinned by the fact of so far existing differences in training and preparation for functioning as PLDDs. So far, existing "uniqueness of this field of specialisation" prevents the migration of physicians into this field. The rivalry between disciplines of PLDD and Paediatrics (child medicine) for long-time employment of paediatricians exists in hospitals” (Czech Republic CA).

Contextual change is another factor accompanying the child health policy and care. As a contextual change, we understood the shifts in the proximal and/or distal child environment. It might be a phenomenon at the macro or micro level. The examples based on which we extracted this category were correlated with, amongst others, the new glance at the early intervention model in Austria, where the Outreach Services mechanism locally called “Frühe Hilfen” was implemented. The goal of it was to improve the development and opportunities for children and parents in the family and society by “support mainly for vulnerable pregnant women, mothers as well as parents to cope with challenges in early childhood (0-6 years)”. The change is going to be achieved “through the cooperation of professionals and institutions in a region and the visualisation and networking of existing offers of help. So-called family companions support families in their home environment. They guide them through the social and health system” (Austrian CA). The change is reflected as well in the improvement of living conditions in the last 4 decades (Portugal) and affected the prevalence of obesity in that country. “The improvement in living conditions has allowed families to acquire goods that foster passive transportation (e.g. cars). Furthermore, the eating habits of the population have been changing; people have left the Mediterranean diet and the consumption of hypercaloric nutrients has been increasing”

(Portuguese CA). More generally it might be linked with the modernization of everyday life (the Iceland case of child and adolescent obesity). Transformations in the family structures expressed by the problems in parenting related to the violence in the school setting, especially bullying, have been identified in Latvia. Signs of changes in parenthood, which accompanied the case of legalisation home births in Estonia, were the overall increase in the number of home births compared to the 1990s and early 2000s, making the issue more relevant for the Estonian public. It expresses not only the shift in the parental attitudes towards delivery and parenthood but may be also interpreted as a turn towards de-medicalization of motherhood and childbirth. The child health reality is affected by the industrial transformations. The advent of the 4.0 Industry, as well as an automation, which is the next step in the digital era, can be considered as one of the predictors of the digital media impact on the mental health of children and adolescents in Germany.

Digital media and its usage in schools is a component of modern **lifestyle** interpreted as a set of behaviours which directly or indirectly may affect positively or negatively the child health status. Lifestyle is also the component which should be taken into consideration while defining child health policy priorities as well. The example of its importance should be noted while discussing the problem of obesity and factors such as diet and exercise (the UK case of obesity). "On a UK level, The Obesity Alliance has called for restrictions on advertising before the 9pm watershed for food and drink products that are high in saturated fat, salt and sugar, investment in active travel, action on reformulation of food and drink high in fat, sugar and salt and a tax on sugar-sweetened beverages. In 2013 the Assembly passed the Active Travel (Wales) Act, which is hoped will boost travel on foot or bicycle rather than by car" (UK CA). Of high importance in the UK was also the debate on the school environment which fosters the obesity and overweight problem. "In England, the risk of being overweight or obese increases as children progress through primary school. In Reception class, around 1 in 5 children are overweight or obese; rising to around a third of children by the time they reach age 10 or 11" (UK CA). The problem of obesity and lifestyle-related issues was reported in Austria, where it was stressed that health behaviour changed in the population. Mainly children and adolescents are sitting several hours a day in front of the TV, or playing computer games. In the discussion on the increased "school autonomy" which led to decreasing the time of physical activity at school, the case in point was less time planned for the sports classes within the school's programs and the problems of high prices for healthy food. In Iceland, sedentary lifestyle, computer usage and the popularity of social media was stressed as an associated socio-cultural factor which affected the discussion on obesity. The case in point was the debate on good access to unhealthy products and a deficiency of effective price policy in place. In Portugal, more attention was given to a lack of using active transportation (e.g. walking, cycling) to travel to school. Although Europe is debating about

lifestyle mostly in terms of obesity and the overweight there are also other patterns which include new dietary trends and alternative nutritional habits. In Italy, the discussion focused on the other phenomenon which can be, to some extent, identified in terms of the healthism movement, as it referred to parents' vegan diet (which) "follows a healthy regime, it lacks food values such as proteins which, in adulthood can be replaced with plant-sourced food. Such a diet can, however, be detrimental to a child, if not correctly followed by doctors, as they need a more varied diet and a proper balance of supplements, vitamins, and proteins" (Italian CA). Those arguments were part of a very vigorous and sometimes aggressive debate between supporters of special diets, and members of the official dietary science, which was extended in time, for example on the damage associated with animal protein, lactose, gluten, etc. (the Italian case of dietary customs and beliefs of parents and their impact on the child).

In the Netherlands, the socio-cultural background of obesity was discussed via the prism of **socio-economic status.** "Certain groups of children are more at risk of obesity than other children. For example, being a child from a migrant family or an ethnic minority increases your likelihood of being obese as a child. The same holds for children from families with low SES, low education, low income, living in bad neighbourhoods etc." (Dutch CA). The problem of child abuse in the Netherlands identifies as a risk group the multi-problem families which may have a low representation amongst other low socio-economic statuses, and additionally other associated problems such as financial debts, lack of a basic level of education, lack of a job, foreigner status or single-parent households.

4.4.2 Structural determinants

Amongst many determinants of child health care and policy, we observed that some of them were of a structural character as well. In our understanding, the structural elements refer to the interrelated components of the system organisation. As our research focuses on the child health the health care system relationships with other systemic elements remain crucial. Thus we decided to divide them into two groups and define them as external and internal determinants. The external determinants relate to the elements indirectly correlated with health care and policy, whereas the internal determinants are those identified within the structure of health care and policy.

Internal structural determinants

Our data, which established the structure of internal determinants, was comprised of interdependent processes such as access to care and provision of care. It highlights also the issues of organisational culture, workforce, and organisational functionality of the system.

The **access to care** as the contextual determinant of child health care and policy was reported by Norway when the case on Sebastian was on the agenda. "A ten-month-old boy (…) died on the way to the central hospital in an air ambulance. Living in the north-western part of the country, in a place with a small hospital where the paediatric ward is closed at weekends.(…) No air ambulance available before late in the afternoon from a regional hospital. On the way to the hospital, the surveillance system in the air-ambulance failed (…)" (Norwegian CA). It initiated the discussion related to the wider context of hospital localisation and access to care. The issue of a policy for "centralisation of services to ensure a large enough volume of care to provide care of a suitable quality was discussed as well. The indirect relationship with the care provision referred to the "conflict between the relationship and independence and responsibility between the local level hospital, hospital trust level, regional health authority level and national level (Minister of health)" (Norwegian CA).

This was not the only case broadly discussed in the Norwegian health care policy scene. The problem of access to care emerged as well when the regional health authorities proposed to closed down the neonatal ward for children born before the 26th week. This provoked the massive reaction at the local level. In the background, the discussion about local communities claiming access to most services despite the questionable quality has also been ongoing for years for obstetric services. A strong local need/tradition of independence was at stake.

The public concern in terms of access to specialist care and medication was raised in Iceland, where the problem of exceeded medicalization occurred. A gradual increase in the use of methylphenidate for ADHD was observed. "The controversy lies in if this increase in use is medicalization of normal behaviour of children or a new phenomenon in child development or a problem that has hitherto been unrecognised. It was also stressed that, contextually, the issue was linked with "good access to child psychiatrists and gradually-improved access within secondary primary healthcare to diagnostic services for ADHD, including psychologists" (Icelandic CA).

In Greece, the controversy related to child mental health was mirrored by the hardship of the economic situation. The concern was raised by the health professionals as mental health issues in children were identified as a consequence of the crisis. On the contrary to the Iceland case, the problem of access to care was "linked to health reform and austerity measures, which have reduced the number of available services, the amount of state subsidy for these services, the number of professionals such as special education assistants, "shadow" teachers etc." (Icelandic CA).

In Latvia, the problem of high maternal and perinatal mortality rates was raised. It was linked with the issues of accessibility of healthcare, regional restructuration of perinatal health

care. This resulted in closing of maternity beds in local hospitals, improvement, and concentration of health care at the regional level. Also, a lack of health care professionals was pointed as a problem, especially in rural regions.

The issues of access to care interrelate to those of **provision of care**. The public concern in Estonia was raised after the fact that the "development plan proposal of the Estonian Health Insurance Fund for 2017-2020, does not include the provision of paediatric services in county hospitals for cost-reduction purposes, which means that paediatric services will only be available in four major Estonian hospitals" (Estonian CA) which met with disapproval of the Estonian professional associations. This change was linked to the implementation of the new regional development strategy for 2014-2020 which aimed at improvement of availability of services. In accordance with the document, some services including "specialist medical care do not have to be available near a person's place of residence, while services that link to basic needs such as primary education, police services, and primary health care must be available in all active regions across Estonia. To ensure that all citizens have access to services that are available only in regional centres, further development of transport links and infrastructure must be carried out" (Estonian CA). The proposed solution can be interpreted in terms of reorganisation of priorities and services provision with the goal of cost reduction.

The contextual baseline for the Finish health care system reform was also linked with debate about the risk of limitation in the access to service provision. The origin of the discussion was the proposal of the health care system change in which more than 300 municipals, which are in charge of providing health care and social welfare services, will be merged into 18 regions. "It has been discussed how maternity and child welfare clinics, as well as school health care, will be placed in this new system, which aims to enlarge entities and centralisation. The discussion was linked to economic crises and the need to downsize the public health services (…) after the recently ended long-term recession. The counter-discussion was on saving for our future, as children are our future" (Finnish CA).

The style of the provision of care might be indirectly linked to the issues of restructuration, as happened in the Irish case, linked with the centralisation of decision making in terms of services provision through the scheme of Discretionary Medical Cards. Discussion about the revision of the eligibility criteria for Discretionary Medical Cards was linked with "centralisation of a process to determine eligibility for free health care (and) led to a significant public debate about how the State should support children with complex or long-term healthcare needs." "This was associated with a significant geographical variation in terms of eligibility criteria, particularly so for Discretionary Medical Cards (…). In 2011, the management of Medical Cards was changed to be centrally managed by the HSE Primary Care Reimbursement Service (PCRS)

in order to streamline the service, reduce variability, improve work processes and improve transparency" (Irish CA).

The collected data underlines the importance of **workforce** questions as well. In the Czech Republic the debate about modification of the proposed system of post-gradual care for medical doctors was strongly linked with the large number of paediatricians and with the high proportion of doctors in the age group 55-75, the risk of the drain of healthcare professionals to other countries, and the debate on income of the medical professions. In Latvia, the problem of workforce shortages was stressed as an important factor determining the mother and child care in terms of high maternal and perinatal mortality rates.

During the strike of nurses in the Child Health Centre in Warsaw, the largest specialist children's hospital in Poland, the workforce demands were strongly highlighted. The context of the case referred to two associated arguments: the insufficient number of medical personnel and the low wages of Polish nurses. "Poor working conditions of nurses are related to, among others, with a small, number of nurses in Poland, compared to the needs of patients. (…) One of the demands of the protesting Child Health Centre nurses was to increase the number of nursing staff because the long-hour work seriously burdens them physically and mentally, and creates a risk for their patients. An insufficient number of nurse personnel is related to, among others, low interest in the profession of nurses in Poland (nurses, despite the fact that their profession is associated with high social prestige, earn little money and at the same time bear a large professional responsibility and their work is hard, physically and mentally). As a consequence, the problem of migration of nurses to other countries emerges, which contributes to the "fast pace of ageing of the nursing staff (the largest number of nurses: in the age groups of "35-44 years" and "45-54 years")" (Polish CA).

When the fire broke out in the intensive therapy ward for premature babies in Romania the issues of the workforce were debated as well. The case was linked to the problem of "questionable political decisions that affected the normal functioning of the health services. One of these decisions was referring to the cessation for an extended period of any employment in all public services, including the health system which was already facing an important reduction in personnel". "The risks for the functioning of the intensive care for premature infants was ignored; the hospital services functioned with the same capacity, but much-reduced staffing, without procedures or regulations of what to do in case of a nurse being alone and she needs to leave the ward" (Romanian cA). The problem of a lack of staff on duty in intensive care for premature infants was highly politicised by being associated with the severe austerity policy, decided by the former Government, and the political party that sustained that government.

This case introduced another contextual factor which was coded as the lack of an organisational culture as a symptom of the **organisational dysfunctionality of the system.** In the Romanian case, the deficit of such was expressed by weak leadership which did not follow the technical maintenance carefully enough. This was accompanied by a lack of respect for the safety procedures including the shortages of appropriate equipment. Additionally, "the medical leadership did not stand up against the political ruling which aggravated the medical personnel shortage so much that it clearly endangered patients' lives" (Romania CA). This situation brought about the discussion about the capability of the Romanian emergency system to respond to emergencies, in terms of basic equipment, workforce issues as well as inappropriate procedures and protocols. This provoked the longstanding debates on the need to invest more in the health system and correct negligence, inappropriate treatment of patients, insufficient staffing and inequalities in health care. The arguments on the dysfunctionality of the Romanian health care system were intensified after the "series of situations where the medical system was put on the spot for being understaffed, not well equipped, and not responsive enough to the suffering of patients. The last case was the death of 58 young people in an underground club fire, in Bucharest, the capital, where besides the club itself, the medical system was accused of a low capability to react in the case of disaster that might endanger many lives; one of the issues was the presumed dishonesty of spokesmen for the health authorities. In the case of the burnt patients, the discussions were about a new hospital for patients who suffered burns, which was reported as a finished investment, ready to be included in the medical system for more than one year, but was still not functioning, so patients were on crowded wards, and medication, as well as technology, were not totally satisfactory, in spite of the huge efforts of the medical personnel. To all these, the media added accusations of corruption, like the huge investments in a hospital for burns, that is not functioning" (Romanian CA).

A lack of organisational culture could be identified as a symptom which led to diagnosing the problem of health system malfunction. The fire in the Romanian hospital, together with the overmedication problem in residential care, is an example of the systemic deficiency in health care organisation. The case related to overmedication created several critics of the Romanian Child Protection system. One of the arguments was that it did not manage to develop a family foster-care system for all its children in care, especially for those with disabilities.

The overall inefficiency of the health system might be observed to some extent in the example of the strike of Polish nurses. "The strike was local and intrastate and is discussed in the context of the overall dysfunctionality of Polish health services. It should be emphasised that, not coincidentally, the strike took place in an institution dealing with specialised, difficult cases: the method of funding procedures drives the hospitals into debt, which means that hospital

managers have a limited ability to raise wages and hire new staff. So, according to both, hospital management and governing party politicians, the problem is not incidental but results from years of neglect of reforming the entire health service in Poland". "The Polish health service is in a state of permanent reform, which increases organisational chaos and hinders comprehensive and systemic changes in the situation of medical personnel" (Polish CA).

External structural determinants

As the child health policy is not being done in isolation, talking about the determinants, we have to take into account factors circulating around the health care which directly and indirectly affect the way the health policy is done or the health care is provided. They may influence the hierarchy of priorities and the position of child health amongst other values. The external structural determinants are interpreted as the factors on a macro level which are influencing the way the problems are solved and the issues are negotiated in the area of child health care. Our data reveal a strong group of determinants in the fields such as the economy, finances, policy and politics.

Child health issues are contextually influenced by the **political initiatives**. In Estonia, the formulation of new government affected the discussion on mandatory vaccination and its potential links with national family benefits. Such a clause proposal was included in the Estonian coalition agreement of 2015. "The case was linked to the agreement of the Estonian Reform Party, Social Democratic Party and Pro Patria and the Res Publica Union on the formation of a government and on the general principles of the action program of the government coalition. This document was the foundation of which the abovementioned family physician stated that linking family benefits with vaccinations is an idea worth considering" (Estonian CA).

The political debates accompanied the discussion on health care on unaccompanied asylum seekers in Finland and the UK. Even though in Finland, politically the discussion was more about restricting immigration than concern for children and their health and well-being, however, regarding children, the very unwelcomed focus has been on the very few adults who claimed to be minors. Also, infectious diseases (especially tuberculosis and vaccinations) have been discussed from the point of view that the asylum seekers would cause a threat to the Finnish population.

In the UK, "while there is a clear concern for the wellbeing of these children, the current political climate is less favourable toward immigration - captured by the anti-immigrant rhetoric spouted by pro-Brexit campaigners in the UK and the growth of far-right parties across Europe". "The phenomenon of Brexit is also correlated with an increase in the reported number of hate crimes suggesting that there is an anti-immigrant sentiment within the UK which is not positive for those who are advocating for greater care for UASCs" (UK CA).

The introduction of changes to the post graduating system for medical doctors in the Czech Republic was the consequence of election promises. “A more simple, transparent and functional system of professional medical education is basically the election promise of the current governmental coalition in the Czech Republic. Professional organisations (including a Czech medical chamber, medical Society of J.E. Purkyně and Association of GPs for children and adolescents) have so far not arrived at a satisfactory consensus with the policy makers and officials of the Ministry of Health and the resulting solution remains the responsibility of the Parliament of the Czech Republic” (Czech Republic CA).

Political involvement was also observed in some cases directly related to problems of child health which were commonly recognised as important. A kind of “political awareness” was observed in cases linked with globally-prioritised issues. In Malta**,** obesity has been on the political agenda for some years and “more recently the opposition put forward a bill on obesity. This was eventually modified as a legislative act on Non-Communicable Diseases known as the Healthy Lifestyle Promotion and the Care of Non-Communicable Diseases Act which was passed unanimously in Parliament” (Maltese CA).

The health of vulnerable children was present in political discussion in the Czech Republic from 2009. Since then, not too many outputs were obtained, but from September 2016 the “inclusive school system” was introduced. On the other hand, lack of “political awareness” of the problem moved the public sentiment in Poland. This happened when parents of disabled children manifested their disapproval for lack of adequate support for people with disabilities. It was claimed that the prior cause of such was the lack of political will and the financial deficit in the Polish budget.

The level of political awareness is expressed by the initiatives undertaken at the **policy** level. This is expressed, amongst others, by the implemented legal solutions. In Latvia, the discussion on the reduction of the children's exposure to passive smoking was accompanied by amendments in the normative document “Tobacco products, herbal smoking products, electronic smoking devices and the fluid circulation law” in order to harmonise with the European requirements. Relatively low prices for cigarettes and easy access were on the agenda as well.

In Poland, the government, introducing the changes in the act on food safety and nutrition, claimed that: “There is no doubt that the emergence of overweight people and obesity, especially among children and young people, is a problem that requires urgent action to effectively eliminate their causes. It is necessary to strengthen policies in the field of public health, in particular, health promotion, conducive to enhancing the knowledge and skills of consumers, enabling them to make healthy choices in nutrition. A risk factor for non-communicable diseases

which are currently the greatest burden of the population is an unhealthy lifestyle, including nutrition" (Polish CA).

In Croatia, changes in laws and ordinances regarding children with disabilities and their parents' rights provoked numerous protests. Parents claimed that the law acts were changed to their disadvantage. The non-profit organisations for the promotion of welfare entitlements for children with disabilities raised their demands. The Ombudsman as well expressed the negative attitudes towards the government decisions.

The potential of the implementation of the new vaccination scheme in Spain brought the fear of deepening the law immunisation coverage rate in families which are at risk of social exclusion, minorities, and middle-class families apparently influenced by anti-vaccine individuals and groups. In accordance with the proposal of the Ministry of Health, Social Affairs, and Equity, both pneumococcal and varicella vaccines were removed from the minimum childhood vaccination schedule. As a result, the national debate started.

In Greece**,** both the introduction of austerity policy and the decision about health reform, "have reduced the number of available services, the amount of state subsidy for these services, the number of professionals such us special education assistants, "shadow" teachers etc." (Greek CA). This, in consequence, influenced the child mental health status.

Policy and politics are not the only external structural determinants of child health policy and care which has emerged from our data. We also observed an important impact of **economic** and **financial factors**. Frequently, the two groups of factors mutually intensified the effects of each other. Austerity policies in Greece or Spain were the consequence of the economic crisis, which has heavily impacted people from lower socioeconomic classes. In Greece, in particular, mounting unemployment has caused intense social problems across the country. Often families have no income due to unemployment of both parents and rely solely on welfare, which is under reform because of austerity measures and is already limited. This situation contributed to worsening poverty and economic inequality affecting mostly the unemployed, single parent families and non-EU migrants and deepened the problem of child poverty and hunger.

When the new vaccination scheme was proposed in Spain, it was observed that public spending cuts were prioritised and less importance was given to the epidemiological and public health issues. Spending cuts in all public services contributed to the problem of child poverty. Particular attention was given to banks' bailout costs and health care spending cuts. "A lack of anticipatory impact assessment of spending cuts in health and the wellbeing of the general population, children and other vulnerable individuals and groups" (Spanish CA) was at stake. In

particular, the recession affected unprotected groups more severely and families placing them at risk of social exclusion.

Severe consequences of economic recession and its impact on child health care and policy were also reported in Portugal. The crisis in the background contributed to both child mental health and the child poverty problem. As a consequence of austerity policies, some families lost the social support which significantly affected their living conditions. Additionally, the mental health status amongst youths has worsened.

The system deficiencies in Romania, illustrated by the example of the fire in the Obstetrics and Gynaecology Clinical Hospital, were linked with the severe austerity policy. Staff shortages was the consequence of questionable political decisions such as cessation for an extended period of any employment in all public services, including the health system. "Given that the nurse was the only staff on duty in this intensive care for premature infants, the media soon identified and accused the lack of staff as being responsible for the tragic event" (Romanian CA).

Ireland was also affected by the global economic situation. The severe consequences were expressed by an increase of the homelessness problem and the number of children and families living in emergency accommodation. Such a situation is related to the "interplay between the economic recession, which started in 2008, and the resultant negative impact on income, employment, and the contraction of the construction industry which contributed to the current housing shortage" (Irish CA). The consequence of the economic recession led to several years of austerity measures. As a consequence, it led to pay cuts and increased unemployment. This contributed to a significant decrease in quality of life and health impairment. The revision of the eligibility criteria for Discretionary Medical Cards and centralization of the procedural steps was also the consequence of the economic downturn. "Centralisation of the Medical Card process was influenced by a need to improve efficiencies and cost-effectiveness, and also to reduce excess spending on the scheme". "Many of those who were refused Discretionary Medical Cards were refused on the grounds that the child's condition did not cause undue financial hardship for the family, suggesting that one or both parents may have been working with an income which exceeded the threshold. However, because many of the families who spoke publically about their experiences were in employment and were tax-payers, there was a sense that this was 'one cut too many for middle-income earners" (Irish CA). The societal reaction came just in time to restore 13,000 Discretionary Medical Cards as an interim measure.

Underfunding of the health and social care provoked limitations in support for disabled children in Poland. Even though there are some financial benefits for children with disabilities, "protesting parents demanded, among others, an immediate increase in attendance allowance (benefit received in cash) in the situation when they have to resign from work to care for their

children, as well as the professionalization of such home care (which means that in the opinion of parents, caring for disabled children should be treated as professional work)" (Polish CA). Poor financial support makes the families to be at risk of poverty and social exclusion when the problem of disability occurs. "In comparison with Western European countries, financial support that can be used by the Polish disabled is lower. So, the most important problem of people with disabilities in Poland, but not the only one, is the threat of poverty which can cause a number of further negative consequences for their social ties, psychological state, and well-being, or the ability for active participation and health" (Polish CA). Another Polish case confirms the impact of financial factors on the child health care and policy organisation. The protest at the biggest children's hospital in Poland revealed several greater financial problems such as low level of health spending from the Polish budget and low wages. "Nurses, not just those protesting at the Child Health Center, draw attention to the low wages as the main problem of their profession. For years, the demand to raise wages has been directed to the government". (…) "There is only 6.3% of GDP (2013) allocated to the health system, which means that Poland ranks 36 out of 44 positions among OECD countries" (Polish CA).

The Lithuanian concern on the appropriate functioning and access to the Child Development Centre for children with developmental and behavioural disorders was linked with political negligence and limited resources spent on it. "In recent years, there has been more than a half a million drop in governmental funding of the Child Development Centre as for all of the paediatric health care" (Lithuanian CA). In Austria, children diagnosed with epilepsy, diabetes, asthma, or mucoviscidosis had more difficult access to schools and/or kindergartens. The reasons of such situations were correlated with the fear of care for a sick child but also a lack of required resources to provide care for the child suffering from the chronic condition. Then the organisation of care and also the financing of care were switched to parents.

4.4.3 International determinants

The international context and the situation beyond the borders of the country is not insignificant for the child health policy and care. Membership in regional and global organisations facilitates diffusion of information and exchange of knowledge but also obligates to respect shared values and adapt to commonly-agreed rules. The globally-published **evidence** may be the unique data, not always available nationally, which illuminates the existence of the problem. This also facilitates the international comparison and drives the discussions which aim to solve the problem. Global reports and comparison studies were stressed by many countries as an important source of information which provoked or supported the national discussion about the existing problem. We could consider it as a local response to the global trends.

An important source of the data was, for example, the HBSC study and other WHO analyses, which were reported as an important source of information in cases correlated with child health. The WHO data was reported as the international determinant which affected the debate on obesity in the Netherlands, as it was claimed that "the discussion about childhood obesity isn't a national discussion, but a global discussion. The WHO has published numbers about this topic" (Dutch CA). Similarly, the obesity issues debated in Portugal used the evidence-based arguments published from the HBSC study.

In Austria, when the problem of a lack of sufficient physical activity at school correlated with obesity, prevalence was discussed with strong reference to statistical data. In the last case, the OECD reports from 2010/2011 provoked the Austrian Health Ministry to establish some measures to promote healthy snacks. Currently, the initiatives are slowing down due to a lack of appropriate financial support.

The UK reported that childhood obesity was considered as an international issue. By reference to global evidence, the WHO Report on Ending Childhood Obesity 2016, it was emphasised there was a strong need for "coordinated cross-sectorial action and a strong focus on actions in pregnancy and early life" (UK CA).

Latvia introduced changes in maternal mortality, taking into account the data reported by the WHO. The cooperation with global institutions had broader effects. "The maternal mortality audit system in Latvia has been developed by the support of The Ministry of Health of the Republic of Latvia. It was organised with WHO-supported training for specialists in 2012 and 2013" (Latvian CA).

The problem of bullying in Latvia was reported in a HBSC study, where it was shown that "an average 14% of Latvian 11, 13 and 15-year-old pupils have suffered from bullying at least 2-3 times in recent months and around 7% of Latvian 11, 13 and 15-year-old pupils regularly suffer from cyberbullying" (Latvian CA).

The antivaccination movement in Europe was strengthened by the Andrew Wakefield article, which was "published in The Lancet as a study on twelve children who seemed to have developed marked behavioural disorders following administration of the MMR vaccine. The disputed research of Wakefield in 1998 was substantially undermined along with the reputation of the doctor in February 2004" (Italian CA). This affected the decision of the judge in Italy, who, referring to the above-mentioned publication, "has imposed the Ministry of Health to indemnify an autistic boy from Agrigento who in 2000 had taken the tetravalent" (Italian CA) vaccine. The international discussion on vaccination safety was the background of the Romanian epidemic

outbreak of 026: H11 E Coli and its potential link with the vaccination and in the Czech Republic and Croatia where the mandatory immunisation was at stake.

The importance of the **evidence** in planning child health policy and care was observed while many national and international initiatives and debates were supported by locally-published data and statistics. In the Netherlands, the reports and data about sexual abuse of children was a consequence of the investigation of Committee Samson and provoked nationwide debate. However, an important role was played by the fact that "in more European countries and the USA there was a surge in reports of sexual abuse in the Roman Catholic Church. The more people reported on their history of abuse, the more people joined in with their own report" (Dutch CA). In the UK, the discussion on child sexual exploitation was taking into account the number of reports and inquiries ongoing in the public domain such as the Rochdale report and the Rotherham Report and other reports on gang and gang-related behaviour. Whereas in Italy, where the illegal dumping waste was at stake, the investigations, reports and a published book contributed to the debate at the national level, but the case became famous in all Europe.

The surge in global and national reports is correlated with **cross-nationality** of many of the child health policy and care issues. The issues correlated with obesity, vaccination, child abuse or care for migrant children are not contained within the border of one country but correlated with the global change of lifestyle, increased awareness of own health thanks to ease of communication and increased awareness of children's rights, linked with institutionalization of child care and shifts in the European normative systems. Often, such cross-national comparison resulted in exchange of views and ideas and learning from the experiences of other countries in order to build their own reality.

Cross-nationality of the public concerns about children increases with the development of the regional integration organisations, which entails voluntary renunciation of autonomy in some areas, and requires regional **harmonisation and unification**. The need for the adaptation of European rules at a national level was supplementing the debates in the Czech Republic about the changes in the organisation of child and adolescent health care. The initiative of merging two specialities was the consequence of the "call for the need to harmonise medical education with other EU countries. The number of specialisations should, therefore, be reduced from the current 46 to 33 fields and the length of their studies shortened" (Czech CA).

In order to reduce children's exposure to passive smoking in Latvia, the undertaken measures were merged the with adaptation of European legislation. Latvian law on "Tobacco products, herbal smoking products, electronic smoking devices and the fluid circulation law" (21.04.2016.) contains legal norms arising from: Directive 2003/33/EC on the approximation of the laws, regulations and administrative provisions of the Member States relating to the

advertising and sponsorship of tobacco products, and Directive 2014/40/EU on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products.

Croatia, as one of the signatories of the UN Convention on the Rights of Persons with Disability in 2007, was obligated to respect the rules of it. Therefore, when rights of children with disabilities and their carers were changed to their disadvantage by introduction of the new law, "this convention was frequently cited in the protests and demands of the non-profit organisation for children with disabilities' rights" (Croatian CA).

The global processes and movements affected many national discussions. One of the most influential was the global economic crisis which influenced the functioning of child health care and policy in most European countries. In particular, Spain, Portugal, Greece, Malta and Ireland were struggling with the problem of child poverty and homelessness. The global humanitarian crisis and the plight of unaccompanied asylum seekers was discussed mainly in the UK and Finland, however the situation of migrant families has also worsened in countries affected by the economic crisis, as they were considered as vulnerable groups. Globalisation contributed to the diagnosis and treatment options; in particular, medication. In Iceland, it facilitated a gradual increase in the use of methylphenidate for ADHD. "The controversy was about the increase in use of medicalization of normal behaviour of children or a new phenomenon in child development or a problem that has hitherto been unrecognised. The discussion has been fuelled by media reports and information campaigns by patient groups and parent groups" (Icelandic CA). Globalisation and global advertising strategies have been determining the problem of children's mental health in Germany. The case referred to the use of digital media like smartphone addiction and its impact, especially on children and adolescents.

4.4.4 Punctual event

The particular situations which contributed to the intensification of the debate were correlated with the socio-cultural, systemic and international factors mentioned above. The scope of those is reflected by behavioural episodes, procedural and institutional episodes, and the global situation. Some examples, which were not mentioned in the previous part of the report, will be described below.

Behavioural episodes are correlated with bottom-up initiatives and actions which affected the wider discussion. In Iceland, the debate on child abuse was fuelled on "one case, which involved two boarding schools (Breiðavík and Silungapollur), schools for children/adolescents with problematic backgrounds, but has now been closed since around the 1970s. Another case involved child sexual abuse in a Catholic school and another in a public primary school. In all

cases, it is a mixture of physical, psychological and sexual abuse. Neglect has also been on the agenda, many reports, but not all verified" (Icelandic CA).

The issue of vulnerable children was discussed in the Czech Republic with the case of "Eva Michálková vs. Norwegian Barnevernet" in the background. Her two sons were taken into protective care after the child reported to a nursery teacher that the father "groped inside his pyjamas"[2]. In consequence, she also lost the parental rights to her two sons.

France is the country suffering from the vaccine hesitancy crisis. This was a partial consequence of inadequate behavioural patterns against the H1N1 pandemic and a lack of compliance with medical procedures. "One of the main errors was to not associate GPs in mass vaccination, although they are known to be key actors in the final decisions regarding vaccination among their patients. But before, controversies about the hepatitis B vaccination deeply damaged the public trust in governmental decisions about vaccinations. France is an exception concerning the vaccine against hepatitis B. It is the only country among those where vaccination is practised, to have had a controversy about the safety of the vaccine, which has lasted from mid-1990" (French CA).

The protest of nurses in Poland was the result of long-lasting unsuccessful negotiations of parents with the government. "The demands of protesting parents from the beginning concerned the increase in the amount of care benefits to the level of the minimum wage in Poland, official recognition of the care of disabled children for work (and caregivers as assistants for disabled persons) and an increase in the amount of benefits for people with disabilities: attendance allowance and disability pension. The first protest took place in 2009 and was organised by the parents joined in the frame of the "Together We Can Do More" Forum. In the protest parents from many places in Poland spontaneously took part" (Polish CA).

The increased prevalence of cancer in Italy, amongst children as well, was correlated with the presence of toxic waste and numerous burnings of waste and because of its impact on the health of the local population. This illegal dumping of waste (even toxic) was a consequence of initiatives of organised crime.

Procedural and institutional episodes which were in the background of child health issues are interpreted as those related to procedure and action correlated with policy changes, and those related to the institution's movement and decisions. The accompanying events were often correlated with the introduction of the new law which intensified the discussion on the specific issues.

[2] https://www.rt.com/news/263625-norway-children-welfare-protest/ accessed 20.02.2017

The French law on marriage for all, also called Taubira law, opened new rights for marriage, adoption and inheritance in the name of equality and shared freedoms. Thus became significant for the debate on contraception, in particular, emergency contraception.

The fire in the Romanian hospital happened when the country was suffering from the consequences of the economic crisis. However the more shocking was that "it occurred one year after the prime minister of that period made public an engagement of rehabilitation of 22 maternity sections in 16 counties of the country. The Giulesti hospital 'Panait Sarbu" is evaluated as the highest level possible - hospital level III - because of the technological equipment and highly-qualified medical personnel, and in spite of this excellent evaluation the fire claimed so many victims, as there was no smoke alarm system, and the procedures for evacuation of patients were not known to the personnel; there were deficiencies in the periodic control of the electric system (fire broke out due to an improvised socket that connected the source of electricity to the air conditioner)" (Romanian CA).

The discussion on obesity in Austria was strongly influenced by the decision to decrease the amount of sport classes at school. Such a decision was the responsibility of the Ministry of Education. The schools, by exploiting their autonomy, contributed to the deepening of the obesity problem.

Many discussions were sustained by the introduction of new regulations of parliamentary decisions. This was the case of Finland where the debate on sexuality education and the doubt of some religious environments whether to cover information on sexual and gender minorities. "The main reasoning has been that it is a child's right to know their biological parents and all children have the right to a mother and a father. "The true marriage", i.e. between a man and a woman, has also been seen as a human right. The Parliament has not decided whether this counter-motion will be discussed or not" (Finnish CA). The acceptance of the gender-neutral marriage act in 2015 was not without significance.

The proposal of new vaccination policies in Estonia, linking the disbursement of family benefits with periodical visits to the family physician, was directly linked with the "coalition agreement of 2015 and the article that mentions the clause of the agreement regarding the linking of family benefits with visits to the family physician" (Estonian CA). In Lithuania, the proposal of the restricted vaccination plan was corresponding to the order on hygiene standards of the Lithuanian Minister of Health which stated that an institution that performs an under-school and (or) pre-school education program has the right to demand the certificate of the child preventive vaccination calendar. In the case of a lack of vaccines against measles, rubella and polio immunisation, such a child cannot be taken to the office. Even though on 5th of June, 2016,

the Constitutional Court, after long debates, decided that this order is against the Lithuanian Constitution and the case was on the political agenda for 2 years.

In Spain, the action accompanying the debate on child poverty was undertaken by "NGOs and health care and social protection organisations. The call for action addressed increasing unemployment, inequalities and groups at risk/vulnerable individuals like children and minorities/migrant families" (Spanish CA).

The case on sedate children in residential homes in Romania was influenced by the initiative undertaken by the Centre for Legal Resources, which controlled "a long list of Romanian family type placement centres for children with disabilities and found that around half of the children looked after in these centres were medicated, for example, with Rispen (Risperdal, risperidone) or Stratera for ADHD and other medication. After revealing the situation in Brasov, the National Authority for Child Protection asked for a re-evaluation of the psychiatric examination, and the results confirmed that the 12 children needed the initially-prescribed medication, the assessment and treatment being correct, administration should be continued" (Romanian CA).

The new form of child abuse, known in the UK as child sexual exploitation, was investigated in Northern Ireland. The case was "linked to Operation Owl, an investigation in missing persons in Northern Ireland. During the course of the investigation, it was uncovered that a higher number of children were going missing more often than others – 13 individual children accounted for 10% of all missing persons, and a further 40 had been reported missing more than 25 times in less than a year and a half. This then resulted in a special investigation into these children" (UK CA). In 2013, Operation Owl led to the identification of 22 suspected cases of child sexual exploitation.

The **global situation** and the global processes were reflected by international factors described earlier in this report. They are related to the phenomena presented at macro level. In particular, respondents mentioned the significance of the migration wave (Finland, the UK) or the economic crisis (Spain, Portugal, Malta and Greece). Additionally, the intensity of the global movements was stressed as well in the case of obesity prevalence at a global level as well as anti/pro-vaccination movements across Europe.

4.5. Vehicle of public expression

The means by which the public express their dismay or support of an initiative or system change can also support or hinder the process of policy development. In addition, public expression can also stimulate change – without debate as to the intended (or unintended consequences of the resulting action). The vehicles of public expression characterise how the public sentiment was raised and continued.

The public feelings were raised by **actors** directly involved in the process of child health care. The initiatives and actions were undertaken mostly by parents and individuals, politicians and academics, experts and stakeholders, and NGO's. They expressed their opinion through **actions** such as protests and strikes, campaigns, debates and petitions or particular behaviours in social media or emotional reactions. Additionally, they were supported by philanthropic and political initiatives. The public attention was maintained through various **communication channels**, amongst which the most common were social media, traditional media and the Internet. The last vehicle of public expression was **information,** which is becoming more readily available, whether via official government internet websites, social media or other channels. The articles in the press, documentaries and educational films, as well as publications of reports, help to keep the issue in the public eye.

The elements mentioned above constantly supplement each other and therefore they cannot be analysed separately. However, it is worth to stress that even though the overlap is noticeable we were able to identify four distinct areas of public expression as shown in Figure 5.

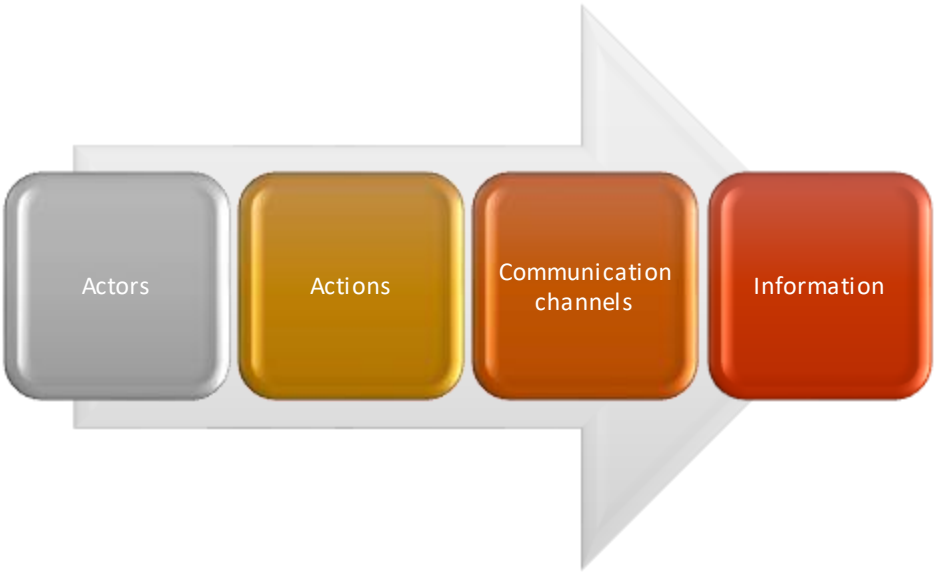

Figure 5: Vehicles of public expression

4.5.1 Actors

Public expression can be performed by the actors directly involved in the process. For example, the issue of obesity in Malta has been promoted by **politicians and academics**. In Estonia, "the public sentiment was largely raised by the IRL politician Liisa Pakosta and continued in various newspaper articles and television programs. Several public figures – mainly well-known Estonian women who had already given birth – commented on the issue" (Estonian CA). **Foundations and other NGO's** were active when a change in the legislation in Ireland took

place. By the development of a strong social media campaign and the establishment of an online petition, they wanted to enable the awarding of Discretionary Medical Cards to children diagnosed with serious illnesses or congenital conditions to a full medical card.

The NGO's involvement was notable in Finland when the migration issue was discussed. In Norway, an 8-year old boy died of child abuse in 2005, and in Romania cases of overmedication occurred in a residential foster home in Brasov. The mass initiative of Paracelsus NGO advocating freedom of choice in vaccination of children in the Czech Republic was widely publicised in newspapers, radio and TV, eventually picked up by the Parliament and Senate of the Czech Republic and on the level of the Ministry of Health and medical professionals. In Poland, during the nurses' strike the public sentiment was raised, especially by the media who presented profiles of children, who fight with "the heartless system". Events in the Polish Parliament were also publicized by the **activity of well-known persons**: "by Anna Dymna – founder and president of the "Despite everything" Foundation, one of the largest charities in Poland to support the sick and the disabled in our country. She sent the letter to parents protesting in the parliament, in which she writes: "The most painful and frightening is the matter that in fact, before our eyes, the greatest value and strength of man – love is humiliated and trampled. The purest and unconditional – love for a child. After all, your children live only because of your boundless devotion" (Polish CA). She was supported by a priest Tadeusz Isakowicz-Zaleski, co-founder and current president of the "Foundation of Brother Albert". The protest was also supported by parents.

Some key figures who oppose the proposed inner-city location of the hospital in Ireland were "high profile and seen as advocates for children, e.g. Dr Fin Breatnach and Jonathan Irwin. Comments and stories from parents have been used on websites associated with opponents to the inner-city location, in order to explain the challenges to access and car-parking. Radio and television have also been used to sustain the debate" (Irish CA).

A significant role in the expression of the public sentiment was played by **parents** who were identified as those raising the public concerns in most cases. Tin Austria, the initiative which expressed the disagreement to the policy towards children with a chronic condition was started by one mother. The significant involvement was observed also in the political area.

4.5.2 Actions

Actors have expressed their opinions through actions such as **public protests** related to the mandatory vaccination, disabled children's rights and child abuse in Croatia or a strike as in the case of the nurses in Poland. "A form of public expression of feeling was also the organisation near to the building of the Centre for Child Health picketing, in which patients using posters with slogans of support, opted for striking staff. The picket was attended by nurses from other health

centres. On the other hand, some group of parents of children also organised the picket and they formulated a request for changing the form of the protest by nurses expressing a fear of it doing little good for the patients" (Polish CA).

Source: The action "I support the nurses' - Child Health Centre (Fig. Agata Grzybowska / Agencja Gazeta)

In Finland, "there have been discussions, social media campaigns and even marches for and against the gender-neutral marriage. The number of people in the marches against gender-neutral marriage („Heterosexual Pride") has been very small compared to the marches for it" (Finnish CA).

The protests were reported in Greece, Italy, Lithuania and Norway as well. In Ireland, Our Children's Health group calling for allocation of Discretionary Medical Cards to children who are already in receipt of the Domiciliary Care Allowance, organised public gatherings outside government buildings and a daily morning vigil at the entrance to the Department of An Taoiseach (Prime Minister) to raise awareness on the issue.

Source: www.independent.ie/opinion/analysis/health-service-on-the-cusp-of-catastrophe-30313787.html

The public protest against the commercial extinction of the trivalent (DTP) vaccine (against the DTP) in France was expressed by a **petition**, which has already collected more than 1 million signatures. "The doctor who is behind this petition is well known for previous positions more openly anti-vaccine and was recently (09/07/2016) sentenced by "le Conseil Regional de l'Ordre des Médecins" (French CA). A similar tool was used in the Czech Republic when in February 2010 "a group of unsatisfied parents published a petition against mandatory vaccination. The petition summarises Czech and worldwide concerns in relation to vaccination. The authors emphasise that in the issue of child vaccination it is necessary to think critically and not in terms of a mandatory vaccination scheme. Although vaccination can prevent the spread of some diseases it can also damage a yet healthy person. Therefore, informed decisions about vaccination considering all the uncertainties, is to be considered and handled as the private choice of parents. This petition also brings attention to the fact that the Czech Republic, which orders a large number of vaccinations as mandatory, not only lacks a system for compensating victims but does not assume any responsibility for the consequences of vaccination" (Czech CA).

Also in the Czech Republic, there is a reference to the system of care for vulnerable children and the plan of unification of services. "The existing system is characterised by considerable fragmentation of departmental responsibilities, a vast number of actors, unclear rules and different financial resources and flows. It dominates a number of stereotypes, prejudices and ingrained procedures. It is criticised by professionals and the public, both at domestic and international level, despite the fact that there are only a few sensitive areas, as with childcare" (Czech CA). Even though the petition against the abolishment of the "special schools / practical

schools" was developed (2012 – 75,000 signatures). The Irish society sustained the public debate on the location of the planned National Children's Hospital through social media and web-based campaigns, e.g. an online petition which raised over 60,000 signatures.

Public sentiment was expressed by various **campaigns** at different levels, in Malta (newspaper and TV campaigns), Ireland and Italy (social media campaigns), and the UK (media campaigns). Some campaigns aimed at increasing the public awareness about the problem, as happened in Ireland when the issue of homelessness was discussed and in Northern Ireland when the problem of child sexual exploitation was revealed. Another way of expressing the feelings were **public and parliamentary debates** (Ireland, Romania and the Netherlands) and **conferences** (Iceland). In some cases, actions were expressed by **philanthropic activities** such as food banks in Spain. Public reactions relied on the **emotional aspects**. The case of Sebastian, who was the victim of child abuse in Norway, moved the society and provoked spontaneous reactions such as flowers at the hospital entrance. In Poland, during the nurse's strike, "the main method of maintaining public attention was stressing the emotional aspect of the events related to the strike. The emotional argument was to pay attention to the potential harm to children who were sometimes presented as innocent victims of "a heartless system," "insensitivity of officials," "nurses concerned only with money" or "political manipulation", etc. The emotional aspect was used especially as a form of pressure on the protesting staff by the ruling politicians, but also by the opposition politicians who accused the government of a lack of interest in the fate of the nurses and their patients. In addition, the media presented the stories of children and their parents who are affected by the consequences of the strike, which also sustained "public sentiment" (Polish CA).

4.5.3 Communication

The means of communication is changing. Although professional groups and official media outlets still have a large influence, new means of communication – particularly **social media**, are rapidly becoming powerful support for campaigns. The e-environment played a crucial role in communication in most cases described by Country Agents. Shocking events were almost always reported in the media (news, newspaper, online etc.) Via online media (websites of papers, social media etc.) discussion was evoked. Parents and other stakeholders (neighbours, family members etc.) were able to speak publicly about it via these channels. Health topics were continuously discussed via various channels and on different levels. Stakeholders sought various types of media to express their opinion to the outside world.

The Croatian case on child abuse deserves special attention here, as it started "when a parent visited the Croatian 'Special Hospital for Protection of Children with Neurodevelopmental and Motor Disorders' and witnessed child abuse by a hospital employee (medical nurse). The parent

then shared what she had witnessed through social networks (Facebook). From there the case escalated into a scandal, with heavy coverage by the media. The media and the general public demanded an explanation from the hospital officials and disciplinary measures for the employee that abused the child" (Croatian).

In the UK, news and social media have been instrumental in raising concerns with images and stories being shared regularly. "There have been a number of protests including the 'Welcome Refugees' march which saw thousands congregate in support of refugees and asylum seekers in Sept 2016. There have also been many petitions launched which both support and oppose refugees and asylum seekers entering the UK and their resettlement" (UK CA).

When in Poland the protest and critic opinions towards the new nutrition law were raised, "in media appeared some information about protests of high school students on the prohibitions associated with unhealthy food. The protesters claimed that they want to decide about their diet. On Facebook, there is also a nationwide petition on amendments to the law on safety of nutrition and food (to liberalise current regulations). There were also some protests of organisations which represent the interests of entrepreneurs and negative opinions of some part of parents and politicians" (Polish CA).

The transfer of information through social media was supplemented by the broad **e-environment and traditional communication channels such as TV, radio and newspapers**. The TV broadcasted thematic talk shows and films. Radio played a supportive role in many cases. The public debates were sustained through web-based initiatives and the press. In Austria, an example to raise public awareness were articles in daily Newspapers or on TV which stress the focus on headlines like: "Each fifth child is overweight" or "the fight against overweight problems/obesity". Also, there were newspaper campaigns, short reports and comparisons of WHO or OECD data regarding overweight problems/obesity in children or a summary of the Austrian Health reports or with rather striking headlines like Our children grow ever fatter" (Austrian CA). Occasionally, printed materials such as posters, leaflets and information brochures were used as well.

4.5.4 Information

Information is shared by active actors, through various communication channels. News has been instrumental in raising all type of concerns. As a result, public opinion and trends have a significant impact on decisions about health systems.

One of the examples of information spread through the TV was the Irish **documentary** about the experiences of homeless families and those living in emergency accommodation 'My Homeless Family'. It was televised one month before the general election in February 2016, and

this, along with the wider debate and statistics showing an increase in homelessness, contributed to making homelessness an election issue. The debate on homelessness was informed by the report entitled Homeless Truths, published in 2012 by the Ombudsman for Children. In this report, the children's experiences of homelessness were described. "In tandem with this, the Ombudsman for Children also launched a series of recordings of the young people's interviews used in the study" (Irish CA). In Latvia, educational films about bullying-prevention in schools and on the Internet (cyberbullying) have been created to respond to the increasing cyberbullying prevalence. The goal was "to help and motivate pupils and teachers to recognise and not ignore bullying, understand the problem, the nature and consequences" (Latvian CA).

Significant sources of information were the national **reports and research**. The Association of Hungarian primary care paediatricians had publications covering the issue of unclear regulations concerning health certificates for children attending summer camps in Hungary. Latvian reports consisted of the statistic on the maternal mortality. In the UK, "charities and other organisations have produced reports on the prevalence and challenges faced by UASCs when they enter the UK and are calling on the government to do more" (UK CA). Also in the UK, the obesity debate was fuelled by the number of reports published by the Scottish Government. For example, in 2015, the Scottish Parliament published a briefing on the health and economic burden of obesity in Scotland. As well as this, it has set targets to reduce the prevalence of obesity. It recently extended the ban on advertising of junk food.

In Italy, the discussion on the Land of Fires and the investigation about it was present in numerous **press articles** and the reports by the Higher Institute of Health, available as Istisan Report. "The data refer to the first study, commissioned by the Ministry of Health to implement adequate prevention strategies. In implementation of a specific article of the law 6 of 6 February 2014 concerning the Land of Fires, the National Institute of Health had conducted an assessment related to mortality data (2005-2011) and hospitalisation (2005-2011) in 55 municipalities in the provinces of Naples and Caserta. In 17 of these municipalities, included in the Cancer Registry of the "Naples 3 South" Local Health Unit, it was also possible to study the incidence of oncological diseases. In July 2014, the data was made available on the website of the Higher Institute of Health, and in September 2015 it was published in the series of ISTISAN Reports" (Italian CA).

5. Conclusions

All primary care systems are subjected to the influence of public opinion, shaped by multiple political, social and cultural influences. In this report, the child-centric determinants of health policy in terms of their context were examined. This will allow us to verify to what extent they are present and influential in the content and processes of primary child health care and policy. The main objective of the study was to explore the contextual determinants of child health care and policy, taking into account socio-cultural background factors.

The importance of context in the process of child health care and policy making is more significant than ever. The changes within the last two decades, such as proliferation of actors, reconfiguration of their power, and the new context of health, provoked the shift from health governance to governance for health. It also shed new light on the factors which influence the style of child health care and policy making. The determinants characterised in this report play a regulatory function towards child health care and policy. They affect public activity which often is the reaction to public discontent. The multiple voices of society participating in the process of child health care and policy making resulted, amongst others, in implementation and/or introduction of the new procedures, action plans and guidelines; influenced the level of awareness, intensified the scrutiny, increased access and availability of services, provoked introduction of structural changes or withdrawing unfavorable changes.

Based on a variety of cultural factors which influence the child health care and policy, while recognising the important role of societal movements, we may conclude that regulatory function of contextual determinants have a broader institutional impact. In the course of our research some relevant patterns emerged:

- Europe's concerns about the child health care are twofold. On the one hand, the attention was devoted to systemic issues (indirect patient orientation) on the other patient/child health and wellbeing (direct patient orientation).
- The child is a central actor in the child health care and policy. The child itself in most situations is not an active participant of the discussion on the shape of child health policy - causative actor
- The child is surrounded by a proliferated network of its representatives - executive actors.
- Executive actors are identified as agents of the child circulating around in the proximal or distal child's environment.
- The proximal environment of the child is understood as the direct milieu of the child on the micro level, whereas distal environment refers rather to indirect surrounding on the mezzo and macro level.

- Actions undertaken in the area of child health care are driven by two groups of interdependent factors: human factors and non-human factors.
- The first group includes those triggered by the actions of the public which we classified as societal-driven and incident-driven initiatives. The second consists of those which are phenomenon-driven, information-driven, procedurally/legally-driven or system-driven.
- The contextual determinants of child health policy were grouped into four diffusive categories of factors: socio-cultural, structural, international and punctual.
- Socio-cultural determinates consist of elements such as societal activation, awareness, communication, trust, freedom, contextual change, lifestyle, tolerance and religion, and history.
- Structural determinants consist of internal and external determinants. External determinants relate to the elements indirectly correlated with health care and policy, whereas the internal determinants are those identified within the structure of health care and policy.
- The group of internal structural determinants is comprised of interdependent processes such as access to care, provision of care. It highlights also the issues of organisational culture, workforce issues and organisational functionality of the system.
- The group of external structural determinants are interpreted as the factors on the macro level which are influencing the way the problems are solved and the issues are negotiated in the area of child health care. These are economy and finances, policy and politics.
- International context and the situation beyond the country matters. The globally-published evidence corresponds with cross-nationality of child health policy issues. Cross-nationality of children's concerns increases with the development of the regional integration organisations, therefore requires regional harmonisation and unification. The global processes and movements are always in the background of undertaken initiatives.
- The particular situations and specific events which contributed to the intensification of the debates were reflected by behavioural episodes, procedural and institutional episodes, and global events/global situation.
- Public expression can take place by the actors directly involved, through actions with the use of various means of communication in order to transfer the information.
- The multiple voices of society in the process of child health policymaking resulted, amongst others, in implementation and/or introduction of the new procedures, actions plans and guidelines; influenced the level of awareness, intensified the scrutiny,

increased access and availability of services, provoked introduction of structural changes or withdrawing unfavourable changes.

As a result of our research, we identified Europe's current child-health issues. It was observed that

- Europe is facing the vaccine hesitancy crisis. The problem may be deepened by limiting access to services, e.g. vaccines, as the consequence of austerity policies and the unfavourable socio-economic situation of Europe.
- The discriminatory movements against children with special needs refer to the lack of sufficient financial support, discriminatory law, limited access to services.
- The child is a victim of an economic crisis. The problem of child and family poverty deepens the social exclusion risk.
- The consequences of changes in behavioural patterns have a broader institutional impact.
- The European trends of settling accounts with history highlighted the scale of the child abuse problem. The problem of "blind eye" needs to be eradicated.
- New forms of child abuse are emerging e.g. child sexual exploitation.
- Europe is facing children's obesity problem.
- The new child mental-health problems are linked with cyberbullying and impact of new technologies.
- The concept of "unwell child" is emerging and refers to the child suffering from mental health problems.
- The system dysfunctionality is expressed by system deficiency in terms of poorly functioning organisation in the case of emergency situations and insufficient infrastructural safety measures.

6. Literature

Boyatzis, R. (1998). Transforming qualitative information: Thematic analysis and code development. Thousand Oaks, CA: Sage.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2). pp. 77-101.

Buse, K., Mays, N., Walt, G. (2005). Making health policy. Understanding public health. London: Open University Press.

Charmaz, K. (2000). Constructivist and objectivist grounded theory. In N. K. Denzin & Y. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp. 509–535). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative analysis. London: Sage.

Charmaz, K. (2008). Constructionism and the grounded theory. In. J. A. Holstein & J. F. Gubrium (Eds.), Handbook of constructionist research (pp. 397-412). New York: The Guildford Press.

Green, J. & Thorogood, N. (2014). Qualitative Methods for Health Research. Los Angeles: Sage.

Glaser, B. G. & Strauss, A. L. (1967). The Discovery of Grounded Theory. Strategies for Qualitative Research. Chicago: Aldine Pub. Co.

Jakubiak, K. (2000). Edukacja rodziców w polskiej refleksji i praktyce pedagogicznej XIX i XX wieku – do 1939 roku. In. K. Jakubiak & A. Winiarz (Eds.) Wychowanie w rodzinie polskiej od schyłku XVIII do połowy XX wieku. Bydgoszcz: WSP.

Leichter, H. M. (1979). Comparative approach to policy analysis. Health care policy in four nations. Cambridge: Cambridge University Press.

Rosa, Matysiuk, (2013). Ewolucja praw dziecka (aspekty filozoficzne, pedagogiczne i prawne). In. E. Jagiełło & E. Jówko (Eds.), Dziecko w kulturze współczesnego świata (pp. 10-33). Siedlce.

Ryan, G. W. & Bernard, H. R. (2000). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.). Handbook of Qualitative Research (2nd ed., pp. 769-802). Thousand Oaks, CA: Sage.

Sikora, M. (2007). Problem reprezentacji poznawczej w nowożytnej i współczesnej refleksji filozoficznej. Poznań: Wydawnictwo Naukowe Instytutu Filozofii UAM.

Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries. The central role of policy analysis. Health Policy and Planning. 9 (4), pp. 353-370.

Wendland, M. (2014). Wiele twarzy konstruktywizmu. Różnorodność stanowisk konstruktywistycznych i ich klasyfikacje. Kultura i Historia. available at: www.kulturaihistoria.umcs.lublin.pl/archives/5004 (accessed: 27.12.2017).

Internet sources:

http://www.who.int/topics/child_health/en/ accessed 27.03.2017

7. Appendices

7.1. WP 1 questionnaire, round 6

Models of Child Health Appraised

(A Study of Primary Healthcare in 30 European countries)

WP1: Identification of Models of Children's Primary Health Care

Task 7: Context and Culture: Identification of public and professional discussions related to child health services

Dear Colleague,

These questions investigate the contextual determinants of child health policy. Health policy does not happen in isolation but is always embedded in a broader societal context. The wide health policy environment includes both systemic and sociocultural elements. Initiatives in health policy are not only directed to the population but also driven by population. When you reply to the question we are exploring to what extent you believe, in your judgment, were the **most influential factors, or topics of public concern** which may have shaped national health policy. We would like to identify the contextual nature of **these influences in your country**

We would like to ask you to identify between 3 and 5 strong **public and professional discussions related to child health services in your country active within last 5 years**. Please describe each of the case using the framework explained above. Please provide as a detailed description of the case as possible, giving extended explanations if you would like.

Note: We are not looking for a deep analysis of current policies; the objective is to report public concern issues which any alert citizen would be aware of, and which will be viewed as pressures or expectations by policy makers.

Please fill in a separate form for each case. And where appropriate provide evidence such as web links or articles (or even photographs) which you feel might be relevant.

Please send your answers to Denise Alexander by 29.07.2016.

Glossary:

Contextual influences are understood as the elements from proximal and distal child health care environment which relate to:

- **Socio-cultural factors** such as: broadly understood social environment (family, peers groups, community, school), lifestyle, social support, social interaction, living conditions, behavioural patterns, ethnicity, minorities issues, norms, values, symbols, beliefs, religion, knowledge etc.
- **Structural factors** such as **political issues**, employment issues, demographic issues, technological issues, institutional issues, health care organisation/delivery/services, economic infrastructure, trade, development etc..

or might be related to:

- **Specific event** which happens in your country unexpectedly such as environmental disaster, conflict or others such as a local affair, planned/unplanned temporal event, planned/unplanned visit of important authority etc.
- **International situation or factors** such as wars, conflicts, cooperation between countries, the introduction of the new international law, migration wave etc.

Object of public concern – actor – is there a focus on a specific profession or another actor (e.g. parents who abuse, doctors who appear not to consider quality)'

Political issue - Political issues cross from the strictly political domain into social and cultural issues if these are deemed important by the voting public and require action on the part of the government. Political issues may become important to the public for various reasons. They may represent everyday issues, such as child welfare, or they may be issues that become prominent in the public view without such a connection

Public concern – a topic is regularly talked about by people or frequently prominent in professional or social media.

Vehicle of the public expression – is understood as e. g. national newspapers, local newspapers, social media, radio, parliament / political debate.

Case N°:

1. **Please specify what the public concern referred to. Describe the case**

For this point please give the detailed description of the issue which was discussed in your country. Please specify which social or health problem was the matter of this public concern (e g. obesity, asthma, disabilities, alleged service deficiencies, etc.). Was there strong controversy, and if so what was it about? Who provoked the public discussion? Parents? Carers? Health care services representatives? Politicians? Foundations? Social institutions? Media/Journalists?

Click here to enter text.

2. **Please specify who was the object of the public concern of the discussed case**

For this point please indicate the main actors of the case of public concern. It might be e.g. infant/child/adolescent, parent, caregiver, teacher, medical professionals etc. Please describe their role in the discussion.

Click here to enter text.

3. **Please specify the area of the public concern**

For this point please specify the area of the case e. g. primary health care, school health, emergency care etc. Please describe.

Click here to enter text.

4. **Please specify when the case happened. Indicate the broader context of the case**

For this point please give the details of the trigger situation (e.g. unexplained death, an election promise, or when a groundswell of feeling became evident) and provide the data details such as year but also indicate and describe the broader context of the discussion.

Please indicate the data details Click here to enter text.

a.	*Please specify if the case was linked to a specific event in your country. Please describe.* Click here to enter text.

b.	*Please specify if the case was linked with structural (including political) elements of your country. Please describe.* Click here to enter text.
c.	*Please specify if the case was linked to socio-cultural factors in your country. Please describe.* Click here to enter text.
d.	*Please specify if the case was linked to the international factors in your country Please describe.* Click here to enter text.
e.	*Please specify if the case was linked to other contextual factors in your country. Please describe.* Click here to enter text.

5. Please specify the level of discussion

For this point please provide the information about the scope of the discussion e.g. national, regional, local. If possible please provide the information how long the issue was of the public concern e.g. episodic discussion, few weeks, few months, few years.

Click here to enter text.

6. Please indicate the principal vehicle of the public expression of feeling

How was this public sentiment raised and continued? E.g. social media; street protest/marches; newspaper campaign; a social media campaign; petition; single high-profile individual (e.g. parent of child 'denied' service); posters/car stickers.

Click here to enter text.

7. Please indicate what were the outcomes of the case, or is it still on-going?

Please specify what were the structural and/or socio-cultural or other consequences of the case?

Click here to enter text.

7.2. List of countries by case description

Case	Country
Lifestyle changes obesity and overweight	• Austria (MIXED) • Iceland (MIXED) • Malta (GP) • Netherlands (GP) • Norway (GP) • Portugal (GP)
Lifestyle - nutrition	• Italy (Paediatrician) • Poland (MIXED)
Lifestyle - smoking	• Latvia (MIXED)
Mother health	• Latvia (MIXED)
Mental health	• Germany (Paediatrician) • Greece (Paediatrician) • Latvia (MIXED) • Portugal (GP)
Environmental health	• Italy (Paediatrician)
Medicalization	• Iceland (MIXED)
Vaccination	• Croatia (Paediatrician) • Czech Republic (Paediatrician) • Estonia (GP) • France (MIXED) • Greece (Paediatrician) • Italy (Paediatrician) • Lithuania (MIXED) • Romania (GP) • Spain (MIXED)
Child poverty	• Greece (Paediatrician) • Ireland (GP) • Malta (GP) • Portugal (GP) • Spain (MIXED)

Child abuse	• Croatia (Paediatrician) • Iceland (MIXED) • Netherlands (GP) • Norway (GP)
Children rights	• Finland (GP) • France (MIXED) • Romania (GP)
Children rights - Discrimination of child with chronic condition/vulnerable child	• Austria (MIXED) • Croatia (Paediatrician) • Czech Republic (Paediatrician) • Poland (MIXED)
System organization	• Czech Republic (Paediatrician) • Finland (GP) • Poland (MIXED)
Access to care	• Malta (GP) • Norway (GP) • Finland (GP)
Provision of services	• Austria (MIXED) • Estonia (GP) • Iceland (MIXED) • Ireland (GP) • Lithuania (MIXED) • Netherlands (GP) • Romania (GP)

7.3. List of cases by country system type

Type of primary child health care system	Country	Cases
Mixed	Austria	• obesity - lifestyle • children rights - discrimination of child with chronic condition • provision of services
	Belgium	
	Cyprus	
	France	• children rights • vaccination
	Hungary	• parents rights to sick pay • organisation of care – health certificates admission
	Iceland	• obesity - lifestyle • child abuse • medicalization • provision of services
	Latvia	• mother health • smoking - lifestyle • mental health
	Lithuania	• vaccination • provision of services - infrastructure • vaccination
	Luxembourg	
	Poland	• system organization - medical personnel • nutrition - lifestyle • children rights - discrimination of child with a disability
	Spain	• child poverty

		• vaccination
	Sweden	
GP	Bulgaria	
	Denmark	
	Estonia	• provision of services • vaccination
	Finland	• system organisation - reform • access to care for migrant children • children rights
	Ireland	• provision of services - infrastructure • provision of services • child poverty
	Malta	• obesity - lifestyle • system organisation - access to care • child poverty
	Netherlands	• child abuse • sexual child abuse • obesity - lifestyle • provision of services
	Norway	• system organisation - access to care • child abuse • obesity prevention
	Portugal	• obesity - lifestyle • child poverty • mental health
	Romania	• vaccination • provision of services - infrastructure • children rights
	UK	• sexual child exploitation • obesity – lifestyle

		• access to care for migrant children
Paediatrician	Croatia	• vaccination • children rights - discrimination of child with a chronic condition • child abuse
	Czech Republic	• system organization - medical education • vaccination • children rights - discrimination of vulnerable child
	Germany	• mental health
	Greece	• child poverty • vaccination • mental health
	Italy	• vaccination • environmental health • nutrition - lifestyle
	Slovakia	
	Slovenia	