Conclusions
With respect to illnesses having an identical relation between the coding system of the paper form and the coding system used in the EMRs (ICPC or any other coding system) the transition from paper form recording to EMRs will be unproblematic. The weekly incidence rates produced by both systems run largely parallel at the same absolute level. Adaptations needed for illnesses without an identical relation will be discussed.

Preventive Child Health Care in Europe – changes and challenges: Workshop of the EUPHA Section Youth

Organiser: Auke Wiegersma, University of Groningen, The Netherlands
Chairpersons: Wiegersma PA[1], Delnoij D[2]
1) president EUPHA Section Youth
2) president EUPHA Section on Health Services Research

The aim of the workshop is to discuss ways to introduce best practice and evidence based medicine in preventive child health care (PCHC) for preschool children based on the experiences of several countries. First, representatives of four different countries – Croatia, England, Iceland, and Sweden – will present the way in which in their countries PCHC is organised, what changes have been made in time, what challenges they face and how they propose to deal with them.

After the presentations we will discuss – together with the president of EUPHA Section Health Services Research, Diana Delnoij – whether the presented systems or parts of it, as well as the evidence for efficiency and effectiveness or the lack of it, could and/or should be used in other countries, given their political, social and healthcare system make-up, what strategies could be used to bring this about, et cetera. If there is any time left after this, possibilities for setting up a comparative study of PCHC in the different European countries will be discussed.

The workshop will last 1 1/2 hours and will immediately be followed by the one-hour annual meeting of Section Youth. During this meeting, the plans for the development of a pan-European interactive website for adolescents will be taken one step further. It promises to be a very interesting meeting with the presentation of new insights and techniques to be used for the development of the European website. For further information on the annual meeting see the summary of the presentation of Aidan Macfarlane on http://members.home.nl/eupha

Challenges for the child health service in NW Europe

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Child health service was developed in NW Europe during the first part of the 20th century. The challenges to child public health today are different. Yet, the outline of these services has only changed little. There are three major problems to address.

Firstly, these services were developed before the era of evidence based public health. Thus, it is often not known if the activities carried out are helpful or not. Core activities, like health examinations, are probably to very useful. Yet, it is hard to remove such activities without restructuring child health services in total.

Secondly, during the time when these services were developed, there was a wide knowledge gap between lay people and health professionals. Today most parents know very much. Moreover, they accept are less willing to accept authority.

Thirdly, the major public health problems today are related to mental health. Yet, the professional training of nurses (and physicians) focus physical health problems. Psychologists participate in child health services but do not have a leading role.

During the seminar, solutions to these challenges will be discussed.

Preventive Child Health Services in Croatia (Hrvatska)

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Throughout its history Croatia has witnessed at first hand several major historical events which undeniably influenced the health of its citizens and especially the children. In the 19th century Croatia was mostly an agricultural country with the typical health problems of that period. The infant mortality rate was very high; in 1874 amounting to 295 per 1000 live births. As a result of the general living conditions causes of infant death were mostly infectious diseases and nutritional deficits. From that day on major changes have taken place; infant mortality is now about 7 per 1000 live births, causes of death mainly being perinatal conditions, and congenital malformations. After the first year the major cause of death is injuries.

From the beginning of the 20th century more and more attention was given to children's health – curative as well as preventive. The last developed mainly after World War II.

In Croatia child health care starts with organized antenatal and parental care. The antenatal care is provided by a specialist gynaecologist and accessible to all pregnant women and covered by a health insurance that is compulsory. More than 99% of children are born in maternity hospitals or special wards. Some of the maternity hospitals have the prestigious title "baby friendly hospital". During the stay in the hospital a BCG vaccination is given to all newborns. Apart from that a the baby is screened for abnormalities of hearing, phenylketonuria and hypothyroidism. After return from the hospital, a community nurse visits the family and newborn several times.

Mothers have a maximum of one year paid maternity leave. After the obligatory period (28 days before delivery up to 6th month of the child's life) the father can take a paid leave.

At one month the first systematic check-up is performed. Further preventive health activities are mostly coincident with the mandatory vaccination for Haemophilus Influenzae, Diphtheria, Tetanus, Pertussis and Polio. Child preventive care is carried out by a paediatrician (who also gives these children curative care) and a specialised nurse, or – if the number of children in a certain area is too small – by the family physician. At school age preventive care is given by a school physician and curative care by a family physician.

The main objective of preventive child health care, apart from vaccination, is to monitor growth and general development of the child, giving advice regarding nutrition, especially breastfeeding, and offering targeted health education.

Nowadays, preventive child health services in Croatia are faced with the challenge to address the many new problems, examples of which are: infant and perinatal mortality, newborn with low and very low birth weight, congenital anomalies, malignant diseases, violent and accidental deaths, child abuse, bullying, mental health and behavioural problems, addiction, etc., etc.

The challenge of quality assurance in preventive child health care in the 21st century– experiences from the UK

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There have been a number of evidence reviews of child health screening in childhood which have led to national recommendations for the provision of evidence based preventive child health services in children and young people in the UK. In the under fives, these are provided by the health visitor and general practitioner(GP) and in the over fives, by school nurses with some support from community child health doctors.

Many traditional procedures and screening methods have been abandoned over the last 15 years in favour of a model of parent and community empowerment to detect and self refer key conditions affecting childrens behaviour and development. There is an increased understanding of the importance of upstream determinants of child health and illness and health professionals are encouraged to target their efforts to those most in need as a means of addressing continuing health inequalities in our communities. How do we ensure that we are providing a relevant, cost effective, equitable and high qualty service?

In this presentation, the role of the locality Child Health Surveillance/Promotion coordinator in the UK is described. The components of such a post include the translation of national policy, setting agreed standards of care, monitoring key child health indicators and encouraging multiagency working. The value of regular feedback of comparative practice and locality based data has been an important step in improving practice quality and raising awareness of current child public health challenges.

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Preventive Child Health Services in Iceland

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Preventive child health services in Iceland have since 1920s been an integral part of normal care and up-bringing of pre-school children. At birth, all families are offered home visitation by a nurse as needed, most often 2–4 times post-partum. Further services by nurses and medical practitioners are delivered within a framework of organized visits to the health centre at the ages of 6 weeks and 3, 5, 6, 8, 10, 12, and 18-months and at 3 1/2 and 5 years of age. The services are run by the state, are free of charge and appreciated as evidenced by high participation rate. Main objective of the visits is to monitor the growth and general development of the child and offer targeted health education. School health services are less well organized but are mainly run by nurses who are supported by medical practitioners as needed at the health centre. The services consist mainly of regular monitoring of the growth of the child, health education and includes support to the child and his/her family as needed.

The essence of current preventive child health services developed when infant mortality and nutritional problems were high on the agenda. Now, with infant mortality at less than 3 per 1000 live births, high participation rate in public day-care centers (more than 90% after the age of three years) and universal participation in primary school, preventive child health services face new challenges. Children are born with very low birthweight (<500 g), at times with long-term developmental problems, and for many severe diseases survival is dramatically improving, e.g., cancer and congenital anomalies. Child mental health, with behavioural problems predominating, is now a high profile issue as well as domestic violence and child abuse. Increasing number of children with foreign background add new dimension and challenge to the services. Further, chronically ill or disabled children attend normal schools in increasing numbers and need special attention. These challenges and future direction of the preventive services in Iceland will be described and discussed, with focus on primary and secondary level of the services.