**HRC resolution 24/11: Preventable mortality and morbidity of children under 5 years of age as a human rights concern**

**Input by the Czech Republic**

**Question 1: Policies to reduce child mortality**

Policy measures related to the reduction of child mortality:

**National Strategy to Protect Children’s Rights and the National Action Plan to Implement the National Strategy to Protect Children’s Rights for 2012 – 2015**

The objective of the National Strategy is to establish a functional system to protect consistently all rights of children and to meet their needs. In particular, the system will seek to improve the quality of life of children and their families, to eliminate discrimination and unequal approach to children and to promote overall development of the child in his/her natural family environment, or as the case may be, in alternative family environments.

Current task of the Ministry of Health is to prepare an analysis of institutional and follow-up services for children (as a part of a comprehensive analysis of care for vulnerable children).

The Ministry of Health works together with the Ministry of Labour and Social Affairs to prepare a detailed analysis of the existing network of services for vulnerable children and families (including analysis of the target group, financial, technical and human resources); the analysis should provide a complete picture of availability and accessibility of the existing services, including their interconnection, for vulnerable children and families within different systems of care (social care, health care, education, etc.)

**Long-term programme to improve health of the Czech population – Health for All in the 21st Century (2002)**

The long-term programme is the Czech Republic’s national instrument implementing the WHO “Health 21” Programme. It defines 21 targets to be achieved through comprehensive policies for the development and promotion of health of the Czech Republic’s population in all sectors. Target No. 3 is dedicated specifically to children. Below is a description of this target, together with an overview of measures taken to implement it between 2003 and 2012.

# Health 21 Programme: Target 3 – Healthy Start in Life:

**BY 2020, ensure BETTER CONDITIONS FOR THE improvement of HEALTH OF NEWBORN AND PRE-SCHOOL CHILDREN AND THEIR HEALTHY START IN LIFE**

The Czech Republic is a country with a very high standard of care for the youngest groups of population. Its overall perinatal mortality rate is one of the lowest in the world. The paediatric care, focusing mainly on prevention, has a well-established system of preventive check-ups to monitor the overall development of children and an immunization programme based on vaccination schedules. Despite the high standard of care, there has been an increase in child allergies and serious behaviour disorders, related probably, inter alia, to nervous system disorders. Morbidity from acute respiratory diseases is high, especially in pre-school children.

**Sub-target 3.1 – Improve access to prenatal and perinatal care**

* The perinatal mortality rate is one of the internationally recognized indicators of the quality of perinatal care and is commonly used in national and international comparison. It has two components: stillbirth rate and early neonatal mortality rate (early neonatal mortality refers to mortality in the first 7 days following the birth).
* In 2011, the stillbirth rate was 2.9 per 1,000 births; the lowest stillbirth rate was recorded in Liberec Region (1.7), the highest in Karlovy Vary Region (3.97). These rates, however low, may vary significantly from year to year, so a multiannual average is considered more representative. Between 2007 and 2011, the five-year average was the lowest in Prague Region (2.1) and the highest in Karlovy Vary Region (3.5), with the Czech Republic’s average rate of 2.6 per 1,000 births. Thus the stillbirth rate has not changed significantly since 2000 when it was 2.8.
* Early neonatal mortality (within 7 days from birth) decreased between 2000 and 2011 from 1.7 to 1.2 per 1,000 live births. The Czech Republic is among the countries with the lowest early neonatal mortality rate in Europe (based on the findings of the Institute of Health Information and Statistics in the WHO “Health for All” database).
* Between 2000 and 2011, the overall perinatal mortality decreased from 4.5 to 4.0 per 1,000 births.
* Intensive perinatal care is provided by regional perinatological centres (combining perinatal and neonatal care), established by the Ministry of Health in 1995. The Czech Republic has a network of intensive perinatological care centres concentrating cases of prenatal and neonatal pathologies, with the aim to improve care for pregnant women, women in labour, postpartum women and newborns. Between 2000 and 2011, the proportion of children born in perinatological centres grew from 29 percent to 34 percent of all births.

**Sub-target 3.2 – Reduce infant mortality**

This target is being fulfilled. Infant mortality decreased from 4.1 to 2.74 per thousand between 2000 and 2011.

* The Czech Republic ranks among the countries with the lowest infant mortality rate in the world. Over the last five years, the average rate has been around 3 per thousand. Between 2000 and 2011, it decreased from 4.1 to 2.74 per thousand. With these rates, the Czech Republic ranks among countries with traditionally low infant mortality rates, i.e. northern European countries (Finland, Sweden, Norway and Iceland), Slovenia and newly Greece. In contrast, former Soviet Union countries, and also Bulgaria and Romania are considered countries with highest infant mortality rates. The low infant mortality rate in the Czech Republic is mainly due to the very low neonatal mortality, especially the early neonatal mortality. Early neonatal mortality (within 7 days from birth) decreased between 2000 and 2011 from 1.7 to 1.2 per 1,000 live births. As regards late neonatal mortality rate (from 7 days to 28 days after birth), the decrease has not been so significant. However, even this indicator decreased from 0.9 to 0.7 per thousand between 2000 and 2011. Besides the Scandinavian countries, lower late infant mortality rates than the Czech Republic’s are recorded in the Benelux countries, Austria, Germany, France and other. In context of Europe, the Czech Republic holds a similar position in post-neonatal mortality rate (29 to 365 days after birth); in 2011, it was 1.3 per 1,000 live births.

**Fig. 3.2.1 Evolution of infant mortality (under 1 year of age) in selected European countries, 2000-2011 (per 1,000 live births)**

0

1

2

3

4

5

6

7

8

9

10

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

Number per 1,000 live births

Austria

Czech Republic

Finland

Germany

Hungary

Netherlands

Slovakia

Sweden

*Source: WHO HFA DB*

* With the increasing number of surviving children, prevalence of late morbidity in children with the birth weight lower than 1,500 g who have reached 2 years of age remains at the same level or has slightly decreased; it remains elevated in children with birth weight lower than 750 g.

**Sub-target 3.3 – Reduce the contribution of congenital anomalies to neonatal mortality**

* Over the last 40 years, the occurrence of congenital anomalies has varied in the Czech Republic. In the last 10-20 years, the number of reported cases of congenital anomalies has increased. However, it is not clear whether the increased incidence is due to an improved system of reporting such cases, improved diagnostics of previously unidentified defects made possible by advanced technologies, higher survival rate of newborns with a low birth weight, or advanced prenatal care (better chance of survival of foetuses, formerly lost in spontaneous abortion), or whether the increase is due to the disruption of the gene pool or changes in the lifestyle of population. The incidence of congenital anomalies also reflects biosocial variations in the population, such as higher age of pregnant women, higher incidence of multiple pregnancies, increase in assisted reproduction (IVF) pregnancies, etc.
* The overall incidence of congenital anomalies (diagnosed in children under 1 year of age) decreased from 414.5 cases per 10,000 live births in 2000 to 357.1 per 10,000 in 2006. In 2007, the proportion of children with congenital anomalies rose to 404.3, and in 2011 to 432.9 per 10,000. Congenital heart defects prevail, accounting for almost 40 percent of all congenital anomalies.
* Certain types of congenital anomalies become less frequent in newborns thanks to advanced prenatal diagnostics (such as neural tube defects, Down syndrome, etc.). However, certain other types are more frequent despite the improved diagnosing methods (renal agenesis/hypoplasia). Some anomalies unidentifiable by standard prenatal diagnostics are also becoming more frequent in the population (congenital malformations of the esophagus, anorectal malformations, etc.).

**Fig. 3.3.1 Evolution of the number of live births and of the incidence of congenital anomalies per 10,000 live births, 2000–2010**

200

250

300

350

400

450

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

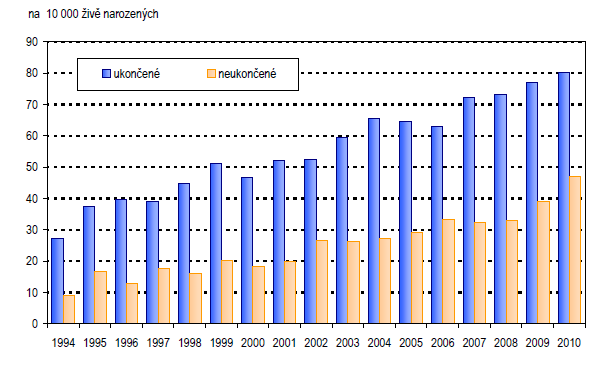
2010

Number per 10,000 live births

*Source: Institute of Health Information and Statistics*

* Early neonatal mortality (within 7 days from birth) caused by congenital anomalies of the nervous system decreased from 5.5 per 100,000 live births in 2000 to 1.7 in 2009; for congenital anomalies of the cardiovascular system, the rate decreased from 12.1 in 2000 to 7.6 in 2009; for congenital anomalies of the respiratory system, the rate remained more or less unchanged (3.3 in 2000, 3.4 in 2009); for congenital anomalies of the urinary system, the rate increased from 2.2 to 3.4 per 100,000 live births between 2000 and 2009. Though the overall rate of perinatal mortality has been decreasing steadily, the mortality due to congenital anomalies continues to account for about 20 per cent of it. Over the recent years, it has accounted for about one third of the overall early neonatal mortality, and about one fifth of perinatal mortality in the Czech Republic. Deaths due to congenital anomalies also occur in late neonatal and post-neonatal period.
* Over the last decades, the Czech Republic has seen an increase in the number of prenatal diagnostic interventions. Whereas their annual number was about 3,500-5,550 in the nineties, it was more then 10,000 at the end of nineties and, in 2010, the number of invasive prenatal diagnostic interventions was 16,511[[1]](#footnote-1).
* Between 2000 and 2010, there was an obvious increase in the total number of prenatally diagnosed congenital anomalies. In 2000, 550 cases were prenatally diagnosed, 75 per cent of which ended in an induced abortion. In 2010, 1,491 cases were diagnosed, about 63 per cent of which led to abortion. The proportion of cases when pregnancies with prenatally diagnosed congenital anomalies did not end in abortion has been growing over the recent years.

**Fig. 3.3.2 Evolution of prenatally diagnosed cases of congenital anomalies, 1994 and 2010**



*Source: Institute of Health Information and Statistics*

**Sub-target 3.4 – Reduce mortality and disability caused by accidents and violence against children under 5 years by 50 per cent**

The target is being fulfilled. Mortality of children in traffic accidents has been progressively decreasing (notably since 2007) in all age groups. Statistics on the number of children physically or mentally handicapped as a result of physical or psychological violence are not available.

* Sudden infant death syndrome (SIDS) is defined as a sudden death of an infant that is not predicted by medical history and the causes of which remain unexplained. In 2000, 7 boys and 4 girls died of SIDS (which stands respectively for 14.9 and 9.1 per 100,000 live births); in 2009, it was 10 boys and 5 girls (16.3 and 8.6 per 100,000 live births respectively). Given the low incidence, it is difficult to identify any trend.
* Child abuse and neglect (CAN) syndrome is defined as a harm caused to physical, mental or social condition and development of a child as a result of any intentional actions of a parent or other adult (maltreatment or inadequate care). There are no precise statistics available on numbers of children suffering from CAN syndrome but it is believed that around 1-2 per cent of children under 15 have experienced some form of violence. According to the Institute of Health Information and Statistics, CAN syndrome was diagnosed in 476 children of the 0-14 age group in 2000 (0.28 per 1,000 children registered with a paediatrician), and in 337 children in 2009 (0.23 per 1,000 children registered with a paediatrician). More data on CAN incidence are also available from institutions of social and legal protection of children, police and non-governmental organisations.
* Currently, there are no complete statistics available on violence against children in the Czech Republic. To illustrate the situation, 5,435 crimes against children[[2]](#footnote-2) (mostly violent crimes and crimes against morality) were recorded in 2007. Institutions that collect such data are the Ministry of the Interior, the Ministry of Labour and Social Affairs, the Ministry of Health, the Czech School Inspection or the Institute of Educational Information. A national child injury register, currently under development, will collect data on injuries which occurred as a result of intentional physical violence.
* Between 2000 and 2009, the number of cases of completed suicide in children between 10 and 14 years of age decreased from 1.9 to 0.6 cases per 100,000 children of this age group. Completed suicides are twice more frequent in boys then in girls.
* Death from external causes (diagnoses V01-Y98, including falls, drowning, assault, traffic accidents, etc.) decreased in boys under 4 years of age and girls between 1 and 4 years of age between 2000 and 2011. In girls under 1 year of age, mortality from external causes was higher in 2011 than in 2000. Considering the low number of cases, it is difficult to observe any trends. As regards mortality from car accidents (diagnoses V01-V99), the incidence decreased in both sexes and both age groups: in the group of children under 1 year of age, there were 4-5 cases per 100,000 in 2000 and none in 2011; in the group between 1 and 4 years of age, there were 3-5 cases and 1 case per 100,000 respectively.

**Fig. 3.4.1 Mortality from external causes (diagnoses V01-Y98) in children under 4 years of age (per 100,000 inhabitants), 2000 and 2011**

*Source: Institute of Health Information and Statistics*

0

5

10

15

20

25

30

0 years

1-4 years

0 years

1-4 years

boys

girls

Number per 100,000 persons

2000

2011

**Sub-target 3. 5 – Reduce the proportion of children with birth weight under 2,500 g by 20 per cent**

* The proportion of live-born children with a low birth weight (under 2,500 g) has had a specific development. It has been observed as a health indicator since the beginning of the seventies, when it was slightly above 6 per cent, and was slowly decreasing until the beginning of the nineties (about 5.5 per cent). This positive trend was due to the rapid development of medical science and better identification of pregnancy risks, enabling mothers to carry the pregnancy to later weeks. From the mid-nineties, the proportion of children with a low birth weight was increasing and it was 7.6 per cent of all live-born children in 2011. The causes of this trend are complex: more children are born from IVF and from multiple pregnancies, the average age of mothers at childbirth is rising (together with a growing proportion of those above 35 years of age) and, therefore, the group of women likely to have premature birth is growing. Moreover, the progress of medical science makes it possible to save children born as early as at 26 weeks of pregnancy or even earlier

**Fig. 3.5.1 Proportion (per cent) of children with a birth weight up to 2,499 g out of the total number of live births, in 2000 and 2011**

0

2

4

6

8

10

Boys

Girls

%

2011

2000

*Source: Institute of Health Information and Statistics*

* The number of newborns suffering from intrauterine growth retardation decreased from 5.1 cases per 10,000 newborns in 2000 to 1.6 cases in 2009.

**Current state of affairs in meeting Target 3**

* Quality of obstetric care is monitored in cooperation with the relevant professional associations. The number of births per one maternity hospital should not be lower than 400 births in one year. Access to obstetric care is ensured for all. Attendance of prenatal check-ups is traditionally high (99.5 per cent in 2011).
* Perinatal healthcare is provided to immigrants within the same regime as other healthcare (including medical coverage). Children of foreigners from third countries cannot be enrolled in a health insurance plan within the Czech Republic’s health insurance system until the place of their permanent residence is determined (they do not meet the requirements of Act No. 48/97 as amended, i.e. have a permanent residence and/or employment in the Czech Republic). Commercial health insurance is based on mutual agreement of two sides and as such, it cannot be enforced by government authorities. For this reason, the Ministry of Health has drafted, based on the relevant Government Resolution, an act on health insurance for children of foreigners to address this problem. However, the act did not pass through the Parliament.
* Over the last few years, the Czech Republic has seen an increase and improvement in prenatal diagnostics of congenital anomalies of the foetus. Along with the increasing number of diagnosed cases, there has been growth in the number of induced abortions due to foetal congenital anomalies. As a result, the incidence of severe congenital anomalies in newborns is decreasing (according to the data available, it is especially the case of Down syndrome and of neural tube defects, such as anencephaly or spina bifida). With the progress of prenatal diagnosing, standard methods of prenatal screening are regularly revised. Modern diagnosing methods are used in risk groups of pregnant women to detect, as early as possible, any irregularities during pregnancy. The record of data on prenatally detected congenital anomalies has been kept in the Czech Republic since 1985: from the beginning, it kept increasing in absolute numbers as well as in the proportion of detected cases per 10,000 live births. Since 1995, the increase has slowed down and, given the current prenatal diagnosing methods, the numbers are not expected to grow too fast in the future. If other methods (such as the first trimester screening) are further developed and become widely used, the number of prenatally detected cases may start growing again. At present, prenatal diagnostics of foetal congenital anomalies in the Czech Republic can be successfully compared to the standards of the most developed European countries.
* Pregnant women carrying a baby that is likely to have a low birth weight or women with high-risk pregnancy are directed to perinatological centres. Such centres have highly specialized neonatal care units, prepared to take care of preterm newborns and newborns with a low birth weight. Some centres offer also follow-up care for high-risk newborns. Children with perinatal burden or related disabilities receive highly specialized medical care covered from public health insurance. Integrated early care for children with perinatal burden has been provided in Pilsen (Pilsen University Hospital) and, since 2010, also in Prague (General University Hospital). In regions, follow-up care for children with perinatal burden is in the competence of perinatological centres.
* The Czech Republic aligns with the recommendation of WHO and UNICEF that infants should be exclusively breastfed for the first six months of their life, receive complementary foods only after the sixth month and continue to receive it together with continued breastfeeding up to 2 years of age. In 2000, the Ministry of Health assumed the role previously played by UNICEF in promoting breastfeeding in the Czech Republic and lending its support to the “baby-friendly” movement. Support and promotion of breastfeeding in the Czech Republic, National Lactation Centre, National Breastfeeding Hotline and a network of baby-friendly hospitals are among the long-term priorities of the Health Ministry’s subsidy schemes.
* In 2008, the Ministry of Health issued a methodological guide, entitled “Steps to be taken by general practitioners dealing with a suspected child abuse and neglect syndrome”. The guide is an updated version of a 2005 guide, and newly includes the problem of commercial sexual exploitation of children, domestic violence, child trafficking, manipulation and harassment. In 2010, general practitioners for children and adolescents were instructed to include examination of health risks, including risks of maltreatment, neglect or abuse in regular preventive check-ups.
* In 2007, the Czech Government approved the National Action Plan to Prevent Child Injuries for 2007-2017. One of its priorities is to establish, by an act, the National Child Injury Register to collect data on intentional and unintentional injuries of children. Pilot data collection project was launched at the beginning of 2008.
* An analysis of the situation of violence against children was made in the context of implementation of the National Strategy to Prevent Violence against Children in the Czech Republic in 2008-2018 (Government Resolution No. 1139 of 3 September 2008). A more detailed analysis of the problem will be possible on the basis of the data concerning violence against children, obtained within the National Action Plan to implement the above National Strategy in 2009-2010 (Government Resolution No. 936 of 20 July 2009) and within the National Action Plan for Transformation and Unification of the System of Care for Children at Risk (Government Resolution No. 883 of 13 July 2009).

**Other policy measures related to Question 1:**

**Health Ministry’s Regulation No.70/2012 on preventive check-ups**

A preventive check-up by a general practitioner for children and adolescents is an age-specific medical examination with the aim to identify health risks, including the risk of maltreatment, neglect or abuse of a child.

**Health Ministry’s Bulletin, part 3, 2008**

In order to bring the issue of child maltreatment, abuse and neglect syndrome (CAN) to the attention of medical community and to ensure a consistent approach of medical professionals, and of general practitioners in particular, to diagnosing, treatment and follow-up of CAN cases, the Ministry of Health issued a methodological guide to be used in all healthcare institutions providing healthcare to children.

**Question 2: Data Collection**

In the Czech Republic, data on mortality in children under 5 years of age (broken down by age and causes of death) are regularly collected. Data on morbidity of this group are available mainly from the National Registry of Hospitalized Patients (data broken down by age and diagnosis). Collection of data on ethnicity and other such characteristics of patients is prohibited by the Act on the Protection of Personal Data.

Data on children from disadvantaged groups are monitored on the basis of statements of activities of their general practitioners – paediatricians. Data available from such statements include numbers of children aged 0-14 from dysfunctional or non-functional families, children maltreated or sexually abused, children using drugs, children with specific learning disorders, pervasive developmental disorders and hyperkinetic disorders. Outputs of these data are available on the website of the Institute of Health Information and Statistics or the Czech Statistical Office (mortality). More detailed data analyses are elaborated upon request and presented in publications on the issue.

**Question 3: Coordination and monitoring of activities, transparency and participation of non-governmental organizations**

**Committee for the Rights of the Child**

Committee for the Rights of the Child is a permanent committee within the Czech Government Council for Human Rights. Members of the committee are representatives of professional community, general public and academic community.

The work of the Committee is to:

* Submit motions to the Council to improve human rights situation and protection in the Czech Republic;
* Draft, together with the Council, the Report on the Human Rights Situation in the Czech Republic and reports submitted as a part of the control mechanisms of international treaties;
* Draft, for the Council, proposals of partial and systemic measures to improve human rights situation and protection in the Czech Republic.

**Health Ministry’s Working Group for the Prevention of Violence against**

The Working Group coordinates the implementation of tasks of the Ministry of Health arising from the National Action Plan to Prevent Violence against Children. The Working Group also collaborates with the Medical Services Department in coordinating interdisciplinary and interministerial activities for the prevention of violence against children. Its members are representatives of government ministries, professional community and civil society.

**Question 4: Ensuring basic hygiene and sanitation standards and access to safe food and safe drinking water**

The Czech Republic ranks among the developed countries with valid legislation and enforceable measures in the field of hygiene, including a network of public health protection authorities. Main legal instrument in this respect is the Act No. 258/2000 on Public Health Protection

The Czech Republic has a system of care for infants and small children up to the pre-school age. All facilities providing such care must be approved by public health protection authorities and have to meet the requirements as regards nutrition, supply of drinking water, and sanitation standards to accommodate children. Operation of these facilities is subject to regular checks by public health protection authorities.

As regards drinking water in general, its quality is regularly monitored in the Czech Republic; regular monitoring covers water in public water mains and public water supply wells, and bottled drinking water, controlled at source as well as on the market. Bottled baby water for infants of 0-12 months, with higher quality standards, is also widely available.

To ensure safe (high-quality) drinking water for public supply is an obligation arising from the Czech Republic’s legislation (laws and regulations) and the whole system of production and distribution of drinking water is supervised by three government ministries (their subsidiary agencies) in all stages of the process:

* Water source protection: the Water Act (Act No. 254/2001) and the Ministry of the Environment;
* Abstraction and pumping of raw water, water treatment for drinking water and supply to consumers (water supply network): Act on Water Supply and Sewerage (Act No. 274/2001) and the Ministry of Agriculture;
* Monitoring of the quality of drinking water at the point of consumption: the Public Health Protection Act (Act No. 258/2000) and the Ministry of Health. Parameters of the quality of drinking water are in line with EC Council Directive No. 98/83/EC on the quality of water intended for human consumption.

Majority of the population use drinking water from public water supplies. Only up to 10 per cent of people are permanently supplied from private or public wells. Childcare, educational and healthcare facilities are considered a part of public water supply even if they use a well; water quality in these cases is subject to the requirements of the Public Health Protection Act and related regulations.

Large water supply systems (over 5,000 inhabitants) fall within the competence of the Ministry of Agriculture. Small water supply systems and public wells are in the competence of the Ministry of the Environment and the Ministry of Health. Water quality in private wells is a private matter and is at the responsibility of the user.

Wastewater sanitation (outside the competence of the Ministry of Health):

* Sewerage: Act on Water Supply and Sewerage (Act No. 274/2001) and the Ministry of Agriculture;
* Discharge of treated wastewater into the environment: Water Act (Act No. 254/2001) and the Ministry of the Environment.

In the Czech Republic, untreated wastewater cannot be discharged into the environment. In places without access to public sewerage and without a wastewater treatment plant, each user must ensure individual wastewater treatment (domestic sewage treatment plant) or collect wastewater in a septic tank (with regular transport of the collected water to a wastewater treatment plant).

Foods for infants and small children are subject to the requirements defined by law and it is regularly monitored whether they comply with these requirements. Children’s food is controlled with special attention. There is an awareness-raising scheme in place informing parents on food appropriate for infants and small children; as for infants, advantages of breastfeeding are strongly emphasised.

**Question 5: Coverage of healthcare and services for children**

The Czech Republic’s laws and regulations concerning healthcare services for children, access to such services and their coverage are fully in accordance with the EU *acquis* and the international law (Convention for the Protection of Human Rights and Fundamental Freedoms, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, Convention on the Rights of the Child).

Healthcare services to children may be provided only by healthcare service providers who comply with the requirements set out in Act No. 372/2011 on healthcare services (material and technical equipment and qualified staff). Conditions for acquisition and recognition of professional competency and special qualifications for medical profession are defined by Act No. 95/2004; Act No. 96/2004 regulates conditions for non-medical professions in healthcare. Medical professionals, including paediatricians, are required to engage in lifelong learning to keep their knowledge up-to-date and to be informed about the newest developments of treatment, prevention and diagnosing in their field of expertise.

To ensure that health service providers provide adequate benefits for services covered from public health insurance, health insurance companies conclude contracts on the provision of health services with the providers. The health insurance company is entitled to control the provider and, in case the services are not properly provided, impose sanctions. Accessibility and time availability of healthcare is regulated by Government Decree No. 307/2012, which defines travel time limits and maximum waiting times for individual health services. For example, general practitioner for children and adolescents must be within 35 min of travel time; the maximum travel times to paediatric specialists, such as neurologists or paediatric surgeons are 90 min. These limits are not applied in cases where emergency care or urgent treatment is required.

In the Czech Republic, regulatory fees are charged on health services. Children under 18 years of age are exempted from regulatory fees for outpatient care. Regulatory fees for hospitalization were cancelled for all groups of patients on 31 December 2013; even before this date, regulatory fees were not charged for hospitalization of newborn children from the date of birth until their release from the hospital. Regulatory fees are not charged for preventive health check-ups; there are at least 9 preventive check-ups scheduled for the first year of a child, at least 6 of them are scheduled for the first six months and at least 3 of them for the first three months (this schedule applies to children who are not in specialized follow-up care). The schedule further includes a check-up in 18 months, in 3 years and then every two years (with a minimum interval of 18 months from the last check-up). As regards dental care, children and young people under 18 years of age attend regular preventive check-ups with a dentist twice a year. These measures ensure that health situation of children is appropriately monitored.

Provisions of Section 46 of Act No. 258/2000 on Public Health Protection, as amended, define measures for the prevention of emergence and spread of infectious diseases. The regulation implementing this Act (Health Ministry’s Regulation No. 537/2006, concerning vaccination against infectious diseases) contains vaccination schedules, regulates conditions for vaccination and methods for detecting immune response. The regulation contains age-specific schedules of compulsory and recommended vaccinations for children. Compulsory vaccinations are covered from public health insurance.

1. Source:GREGOR, Vladimír. Vrozené vady u narozených v roce 2008. Prague: ÚZIS – Institute of Health Information and Statistics, 2008. Chap. Prenatální diagnostika vrozených vad v ČR v roce 2008, p. 157. Available in Czech at: <http://www.uzis.cz/system/files/vrozvnar2008.pdf>. [↑](#footnote-ref-1)
2. National Strategy on Prevention of Violence against Children in the Czech Republic for 2008 – 2018, available in Czech at http://www.vlada.cz/scripts/file.php?id=61422 [↑](#footnote-ref-2)