ASSESSING AND IMPROVING SCHOOL HEALTH SERVICES IN THE WHO EUROPEAN REGION

Findings from nine countries
ASSESSING AND IMPROVING SCHOOL HEALTH SERVICES IN THE WHO EUROPEAN REGION

Findings from nine countries
Abstract

In the frame of the WHO-Russia initiative on improving school health services in the Eastern European and Central Asian countries the WHO Regional Office for Europe and the Russian Federation promoted the assessment of school health services in 9 countries of its Region (Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Russian Federation, Tajikistan, Uzbekistan). This comparative report synthesizes findings of the country assessments identifying major strengths of their school health services and areas for improvement in accordance to the standards of the European Framework for school health services. The document puts together action points as well as executive summaries of the country reports.

Document number: WHO/EURO:2022-5938-45703-65694

© World Health Organization 2022

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition: Assessing and improving school health services in the WHO European Region: findings from nine countries. Copenhagen: WHO Regional Office for Europe; 2022".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (http://www.wipo.int/amc/en/mediation/rules/).

Suggested citation. Assessing and improving school health services in the WHO European Region: findings from nine countries. Copenhagen: WHO Regional Office for Europe; 2022. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Sales, rights and licensing. To purchase WHO publications, see http://apps.who.int/bookorders. To submit requests for commercial use and queries on rights and licensing, see http://www.who.int/about/licensing.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.
# TABLE OF CONTENTS

Acknowledgements ................................................................................................................................................ V

Abbreviations ................................................................................................................................................... VI

Executive summary ........................................................................................................................................ VII

Background ........................................................................................................................................................ 1

European framework for quality standards in school health services and competences for school health professionals ......................................................................................................................... 1

Assessment tool for school health services in the WHO European Region ......................................................... 2

A human-rights based approach to health ........................................................................................................ 4

Assessing SHS in a group of nine countries in the European Region .................................................................. 8

Findings ............................................................................................................................................................... 11

Overall SHS landscape including financing ........................................................................................................ 11

Standard 1: legal framework ................................................................................................................................ 11

Standard 2: child- and adolescent-friendly health services .............................................................................. 13

Standard 3: SHS facilities, equipment, staffing and data management systems ............................................... 17

Standard 4: multi-stakeholder collaboration ...................................................................................................... 19

Standard 5: workforce competencies .................................................................................................................. 21

Standard 6: service packages .............................................................................................................................. 22

Standard 7: data management systems ............................................................................................................... 24

Current challenges for SHS .................................................................................................................................. 25

Action points ......................................................................................................................................................... 26

Conclusion and next steps at the country level ..................................................................................................... 31

References ............................................................................................................................................................ 34

Annex 1. Number of schools engaged per participant country ........................................................................... 35

Annex 2. Overview of school health landscape in nine countries ........................................................................ 37

Annex 3. Survey of country coordinators ........................................................................................................... 39

Annex 4. Executive Summary: Armenia ............................................................................................................... 41
Annex 5. Executive Summary: Azerbaijan .................................................................................. 46
Annex 6. Executive Summary: Belarus .................................................................................. 50
Annex 7. Executive Summary: Kazakhstan ............................................................................. 52
Annex 8. Executive Summary: Kyrgyzstan ............................................................................... 55
Annex 9. Executive Summary: Russian Federation ................................................................. 56
Annex 10. Executive Summary: Tajikistan ............................................................................. 58
Annex 11. Executive Summary: Uzbekistan ........................................................................... 61
ACKNOWLEDGEMENTS

This report has been prepared by Ana Isabel F. Guerreiro, an international expert in children’s rights, and Susanne Stronski, a paediatrician and specialist in adolescent medicine, in consultation with Aigul Kuttumuratova (WHO Regional Office for Europe) and Olga Komarova (WHO Collaborating Centre for improving services for children, National Medical Research Centre for Children’s Health, Moscow, Russian Federation). Many national experts have contributed to the assessments carried out and the preparation of the final national reports for the nine participating countries. The WHO Regional Office for Europe recognizes the efforts and commitment of all those involved throughout the process.
### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATOD</td>
<td>alcohol, tobacco and other drugs</td>
</tr>
<tr>
<td>CRC/UNCRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
</tr>
<tr>
<td>HP</td>
<td>health promotion</td>
</tr>
<tr>
<td>HRBA</td>
<td>human rights-based approach</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>QI</td>
<td>quality improvement</td>
</tr>
<tr>
<td>SES</td>
<td>socio-economic status</td>
</tr>
<tr>
<td>SHS</td>
<td>school health services</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>YFHS</td>
<td>youth friendly health services</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Background
In the WHO European Region, where schooling rates are close to 100%, the school setting provides a unique opportunity to reach an entire population group — school-aged children and adolescents — in the same place, regardless of their social and economic status (SES). By providing equal access to health promotion and preventive health services and monitoring health, growth and development, school health services (SHS) make a significant contribution to reducing inequalities by optimizing health, advancing learning, and improving educational outcomes for all children and adolescents. As part of the efforts to implement the Russia–WHO initiative on improving school health services in the Eastern European and Central Asian countries, the WHO Regional Office for Europe and the Russian Federation promoted the assessment of school health services in nine of the region’s countries in 2020–2021.

Objectives
The objective of this project was to support nine countries of the WHO European Region in assessing current national regulatory frameworks, as well as the delivery of SHS, as a means to improve the quality of services provided.

Methodology
An Assessment Tool on SHS in the WHO European Region was prepared based on the “European framework for quality standards in school health services and competences for school health professionals” and the human rights-based approach, as provided by the United Nations. A package was created to support a comprehensive assessment, including by engaging with multiple stakeholders, which was used by the participating countries to assess national legal and regulatory frameworks concerning SHS and service delivery.

The phases of the project were as follows:

1) Preparatory phase: development of the assessment tool, guidance and capacity-building
   - Development (2019/2020) of the assessment tool for school health services in the WHO European Region;
   - Development of complementary guidance and tools for multiple stakeholders;
   - August–November 2020: a series of four capacity-building seminars for the national coordinators of the nine participating countries.

2) Assessment in countries (November 2020 – January 2021)
   1. Desk review of the SHS national legal and regulatory frameworks using the Assessment tool;
   2. Semi-structured interviews with key informants;
3. Focus group discussions with stakeholders (children, adolescents, school nurses, teachers, parents and school administration);

4. Online country consultation between individual country coordinators and international experts.

**Limitations**

The SHS assessments were performed in the context of the COVID-19 pandemic. For this reason, capacity-building on the assessment process was limited to online training and no country visits took place to support country representatives.

Secondly, the samples used for the focus group discussions may not represent the variety and complexity of issues present to different child population groups, specifically vulnerable groups, or other characteristics that may influence the quality of SHS (i.e. being a school in a rural, mountain or otherwise remote area).

**Main results**

The following countries participated in the assessment: Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, the Russian Federation, Tajikistan, Uzbekistan.

A summary of the findings is given below. However, it is important to note that each country has different characteristics and therefore will need to develop organizational models that are appropriate to its setting, including the health priorities of the population and the existing health system.

**Strengths**

**National Framework and overall landscape of SHS**

- An appropriate national regulatory framework based on the CRC is in place in several of the countries, including regulation of SHS and principles of adolescent-friendly health care services, developed in collaboration with the education sector.

- SHS are available and accessible to all school children in most countries and are free of charge.

**Principles of child and adolescent friendly health services**

- All participating countries demonstrate ongoing work and attention to many of the dimensions of child and adolescent-friendly health services, including equality, accessibility and acceptability.

**Infrastructure (facilities, equipment, availability of health promotion material)**

- Most countries provide specialized medical rooms in the majority of schools, with essential equipment and emergency medication on stock.

- Most countries have developed health promotion material at national level.
Collaboration between SHS, Schools, children and parents and local community actors

- Many countries report well developed collaboration with stakeholders at the school level, and some collaboration with stakeholders at the community level.
- Some countries facilitate communication within school and with parents through dedicated websites or social media networks.
- Most countries report that SHS have a developed referral system.

Staff (including job description, competences, motivation)

- Most countries have clear job descriptions for SHS-staff and some have postgraduate training with periodic recertification processes.

Service Package of SHS

- All countries provide immunization and a wide range of screening services for physical/developmental pathologies. Some countries also provide screening for mental health problems, as well as for the identification, treatment/referral and prevention of infectious diseases and some NCDs.

Data management systems

- In most countries, data management systems are available and are compatible with data protection requirements. These systems allow access to children’s health information and could be used for reporting and informing decision-making process at the policy level.
- Five countries have started developing an electronic health information system, or already have one in place.

Weakness and challenges

National Framework

- Most frameworks were developed without the participation of children, adolescents or their caregivers.
- There is a lack of regulation for implementation (guidelines, standards, evidence-based clinical protocols, standardized qualification requirements, content [specifically, the prevention of NCDs], and financing).

Principles of child- and adolescent-friendly health services

- The assessment found variations in terms of accessibility, the availability of services, including inconvenient operating hours and insufficient time allocated by SHS staff, but also the availability of evidence-based protocols and guidelines, as well as the competencies of SHS professionals.
• Despite the legal framework in place, insufficient attention is paid to several principles of adolescent-friendly services and child rights in SHS (i.e. participation in health care decision-making processes, individually and as a group, and confidentiality).

**Infrastructure (facilities, equipment, availability of health promotion material)**

• There is significant heterogeneity between rural and urban schools, with rural schools often lacking medical rooms, adequate environmental conditions and infrastructure/equipment, and conditions that guarantee confidentiality.

• Health promotion material is mostly developed without the participation of children or adolescents or parents.

• In some cases, health promotion material is not made available to children and their families.

**Collaboration between SHS, schools, children, parents and the local community**

• Parents are not well informed about SHS in general and about SHS activities involving their children.

• The motivation and potential of parents to contribute to health promotion activities in schools is not used adequately.

• There is a lack of communication with local health professionals, which sometimes hampers the continuity of care for referred children.

**Staff (including job description, competences, motivation)**

• Several countries have insufficient training at the undergraduate, postgraduate and continuous education levels.

• Many countries report the staff-to-children ratio is lower than the average, resulting in a high workload. Other related problems include inappropriate use of working hours and lack of time for professional development, monitoring work and research activities.

• Low motivation of SHS professionals, associated with low salaries compared to those for similar jobs in primary or hospital health care, insufficient time, and the lack of incentives for professional development. Frequently, SHS staff are close to retirement age. Some countries lack mental health staff in SHS.

**Service Package of SHS**

• Often, screenings and interventions are not based on public health concerns, are not evidence based or are outdated.

• SHS service packages in some countries do not address the needs of children with physical disabilities or those with chronic conditions. In addition, mental health and Sexual and Reproductive Health (SRH)-related issues are not sufficiently addressed in several countries, if at all.
• In many countries, service packages are rather limited in rural areas.

**Data management systems**

• Collected data, specifically when only paper-based, is not used sufficiently for monitoring the quality of health services and identifying health priorities.

• Excessive and unnecessary paperwork should be reduced, and existing registers improved, with clear objectives stated.

• The use of electronic systems, if they exist, is hampered by the lack of electronic devices in the SHS.

**Action points**

The following common action points have been identified:

**National Framework, leadership and governance**

• Strengthen the national regulatory framework, including:
  
  o Adopting legislation and/or policies on principles of adolescent-friendly health care services;

  o Identifying health priorities that need to be addressed;

  o Adopting regulations for implementation (guidelines, standards, evidence-based clinical protocols, standardized qualification requirements, content [specifically, the prevention of NCDs] and financing);

  o Defining processes to involve children and adolescents in the design, development and assessment of SHS, policies and programmes.

**Principles of child and adolescent friendly health services**

• Harmonize the availability of services across the entire territory of the countries, ensuring that there are as few discrepancies as possible between rural and urban areas or other dimensions where inequalities have been identified;

• Develop practical tools, protocols, awareness-raising activities or other actions that make it possible to implement existing national legal frameworks to promote the principles of child- and adolescent-friendly health services;

• Better adapt school health services to the needs and characteristics of children and adolescents;

• Enhance the implementation of the child’s right to participate, by taking their views into account.

**Infrastructure (facilities, equipment, availability of health promotion material)**

• Allocate sufficient resources to implement SHS standards across the whole country (in urban and rural regions), for all age groups and in all schools (public
and private);

- Establish sustainable processes for restocking medical supplies;
- Promote the participation of children and adolescents in the development of health promotion materials at the national, regional and local levels;
- Ensure that health promotion activities are available to all children and parents, e.g. by finding new ways of delivery, including through websites and social media.

Collaboration between SHS, schools, children and parents and local community actors

- Develop models of participation and multidisciplinary collaboration for SHS within schools, with stakeholders of the health system and community actors;
- Develop systematic information targeting parents, as most appropriate to each setting;
- Involve children, adolescents and parents in health promotion activities.

Staff (job description, competences)

- Develop unified training programmes (undergraduate, postgraduate and continuous medical education) for SHS staff, enabling them to address priority health problems with up-to-date knowledge and skills;
- Revise and update competencies and terms of references of all categories of SHS staff to better meet the needs of school-age children and adolescents;
- Develop and implement recruitment protocols, provide supportive supervision and feedback for staff, and provide conditions for research activities by SHS staff;
- Develop additional systematic mechanisms for quality assurance, such as recertification and monitoring;
- Secure adequate budgets for SHS staff salaries.

SHS Service Package

- Clearly define public health priorities that should be addressed by the interventions of SHS;
- Develop evidence-based protocols and guidelines for the content of service packages delivered;
- Provide adequate conditions for regular assessment of SHS screenings to ensure these are evidence-based; non-evidence-based screenings should be revised or abandoned.

Data management systems

- Develop a countrywide, unified, adaptable Health Information System (HIS) for SHS that can interact with the HIS of other health care systems in the country,
in compliance with data protection requirements;

- Provide a sufficient number of electronic devices in SHS and user training;
- Develop a unified set of public health indicators, allowing data from various health care systems to be compared.

**Conclusion and next steps at the country level**

On 18–19 November 2021, a Final Conference was held in Moscow with representatives from the nine participating countries to exchange views on the findings and discuss the way forward. The participants also presented some of the steps they had taken at the country level. The focus was put on strengthening legal frameworks, improving quality standards and their implementation, establishing monitoring and evaluation systems, moving towards the digitalization of services, intensifying staff training and developing new approaches to health promotion. A short discussion of the Assessment tool revealed that the participating countries appreciated its usefulness and considered the guidance for the assessment processes to be clear and helpful. They also noted the need for further technical and financial support from WHO. WHO stated that there were plans to provide further support to countries and the process as a whole, including by publishing reports, facilitating a dialogue between stakeholders, developing action plans and providing an updated package of assessment tools and lessons learnt.
BACKGROUND

European Framework for Quality Standards in school health services and Competences for School Health Professionals

In the WHO European Region, where schooling rates are close to 100%, the school setting provides a unique opportunity to reach an entire population group – school-aged children and adolescents – in the same place, regardless of their social and economic status (SES). By providing equal access to health promotion and preventive health services and monitoring health, growth and development, school health services (SHS) make a significant contribution to reducing inequalities by optimizing health, advancing learning, and improving educational outcomes for all children and adolescents. In 2014, the World Health Organization (WHO) published the European Framework for Quality Standards in school health services and Competences for School Health Professionals (1) (hereafter the European Framework) to support the Member States of the WHO European Region to advance the quality of their SHS as part of their national health systems (see Box 1). The European Framework identifies standards that are intended to guide national decision- and policy-makers in planning and improving new and existing SHS. The standards are intended to provide SHS with varying organizational models to respond to the health needs of school-aged children and adolescents in the specific national context. The framework is comprehensive and addresses essential standards that must be met in order to achieve the best quality care for all children within the specific national context (e.g., the specific epidemiology of the country, the particularities of the national health care system, etc.). This includes the national or regional normative framework, the competencies of health professionals, financing, infrastructure, the content of services provided, and data management systems, as well as the principles of child- and adolescent-friendly health services.

Box 1. Standards for school health services

**Standard 1.** An intersectoral national or regional normative framework involving the ministries of health and education and based on children’s rights is in place to advise on the content and conditions of service delivery of SHS.

**Standard 2.** SHS respect the principles, characteristics and quality dimensions of child- and adolescent-friendly health services and apply them in a manner that is appropriate to children and adolescents at all developmental stages and in all age groups. Principles of accessibility, equity and acceptability also apply to the way in which SHS engage with parents.

**Standard 3.** SHS facilities, equipment, staffing and data management systems are sufficient to enable SHS to achieve their objectives.
Box 1. Standards for school health services (cont.)

**Standard 4.** Collaboration among SHS, teachers, school administration, parents and children, and local community actors (including health care providers) is established and respective responsibilities are clearly defined.

**Standard 5.** SHS staff have clearly defined job descriptions, adequate competences and a commitment to achieving SHS quality standards.

**Standard 6.** A package of SHS services based on priority public health concerns is defined, supported by evidence-informed protocols and guidelines. The service package encompasses population-based approaches, including health promotion in the school setting, and services developed on an approach based on individual needs.

**Standard 7.** A data management system that facilitates the safe storage and retrieval of individual health records, monitoring of health trends, assessment of SHS quality (structure and activities) and research is in place.

Assessment tool for school health services in the WHO European Region

The European Framework provides key standards to guide decision- and policy-makers, as described above. However, the standards must be understood and applied as part of the planning and improvement efforts of national health systems. For this purpose, the WHO Regional Office for Europe has developed an Assessment tool for SHS to help countries assess and improve their services. This work is part of an ongoing process at the international level that aims to improve the quality of health care services for children and adolescents and to ensure compliance with children’s rights standards, as enshrined in the Convention on the Rights of the Child (CRC). The development of this assessment tool is based on a variety of existing WHO Frameworks, strategies, reports and manuals (2–6), and adapted specifically for SHS.

The Assessment tool addresses in detail the seven standards included in the European Framework from different perspectives:

- What is the normative framework that is in place?
- What services (and equipment) are available and to what extent do they respond to the health needs of children and adolescents?
- What competencies does the workforce have?
- To what extent do children and adolescents benefit from existing services?
- What are the views and experiences of children and adolescents of existing services?
In this respect, the development and aims of the Assessment tool must be understood in relation to the principles of quality improvement (QI). In line with WHO’s Regional Framework for Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in the WHO European Region (7), all countries in the region should improve the quality of health care services for children by:

- integrating human rights provision in QI processes;
- identifying key areas for improvement;
- addressing bottlenecks that hinder the provision and continuum of care within health services and beyond;
- implementing a continuous and sustainable QI system;
- enhancing the implementation of human rights provisions and improving monitoring and reporting to UN Human Rights Treaty Bodies.

The Assessment tool has therefore been designed to carry out a baseline assessment of SHS at the country level that allows us to assess the quality of currently available services and identify gaps and areas for improvement. This is a comprehensive exercise that should involve coordination and/or collaboration between the Ministry of Health (MoH) and the Ministry of Education (MoE) and lead to a national dialogue and planning process. For this reason, the Assessment tool is of a qualitative nature, even though elements of a quantitative nature should also be taken into account. As mentioned above, the implementation of the Assessment tool should enable those in charge to understand the extent to which children and adolescents are effectively benefitting from services. This means all children and adolescents, whatever their socioeconomic status, whether they live in urban or rural areas or any other circumstances. The Assessment tool also includes questions that look specifically at the experience of children and adolescents of the services in place. This aspect is further developed in the next section.

The Assessment tool places special emphasis on the content of services provided. Services should respond to the actual health and well-being needs of children. Some of the principles that have guided the development of the tool are prevention, early identification and adequate, timely interventions that are evidence-based. One major public health concern is that screening should be based on several principles, i.e., it should address an important health problem (that has high or increasing incidence or prevalence, or causes substantial morbidity or mortality), uses an accurate, reliable and reproducible screening test, causes more benefits than harm and – considering the full cost-to-benefit ratio – the screening should be superior to other alternative interventions, such as primary prevention (8).

A strength of the Assessment tool is that it collects and analyses qualitative information from different groups of stakeholders involved in SHS, identifying gaps and defining root-causes of areas for improvement. The Assessment tool strives to advance the endeavour started previously and aims to help identify areas for improvement and raise awareness about the quality of SHS and the degree to which children’s rights are respected.
A human-rights based approach to health

In 2003, the United Nations agreed on a Common Understanding on the Human Rights-Based Approach (HRBA), which is to guide all of its actions (9). A human rights-based approach requires systematic attention to a range of human rights standards and principles (10). Specifically, a human rights-based approach to health includes seven elements, as described in Box 2 (11).

**Box 2. Elements of a human-rights based-approach to health**

1. Availability
2. Accessibility
3. Acceptability and quality of facilities/services
4. Participation
5. Equality
6. Non-discrimination
7. Accountability

Relevance of the HRBA: In the European Region, all countries have ratified the Convention on the Rights of the Child, which means that all national and regional agencies and services have an obligation to systematically respect, protect and fulfil child rights standards.

There are many ways through which countries apply child rights standards, such as through the implementation of:

- relevant national strategies and frameworks (i.e. Framework on SHS, child health, child rights, etc.);
- awareness-raising of stakeholders on child rights and its applicability to health, as well as quality health care;
- setting up accountability systems;
- implementing the Concluding Observations of the Committee on the Rights of the Child (see Box 3).
FINDINGS FROM NINE COUNTRIES

Box 3. Reporting Process under the Convention on the Rights of the Child

After ratification of the Convention on the Rights of the Child, each country is obliged to integrate the rights and standards enshrined in the Convention into its domestic legislation. This means that in all European countries there should be a related body of legislation and policies that make reference to children’s rights (i.e. the principle of the best interests of the child, the right to access health care without discrimination, the right to participate in health care decision-making processes, and so on).

Secondly, countries are obliged to report to the Committee on the Rights of the Child, which is the body at the United Nations that follows the implementation of the Convention on the Rights of the Child. As part of this process, countries prepare a national report every five years on the status of implementation of the Convention. This includes the implementation of child rights within the health care system. At the end of this process, the Committee on the Rights of the Child issues its Concluding Observations, which includes recommendations to Member States on how to improve the implementation of child rights in their specific context.

The Concluding Observations are public and can be accessed in English, Russian and other languages.

For more information see: OHCHR Fact Sheet No.10 (Rev.1) (12), The Rights of the Child or Child Rights Connect. The Reporting Cycle of the Committee on the Rights of the Child: A guide for NGOs and NHRI (13).

Ultimately, respecting child rights and following a human rights-based approach leads to better outcomes for the entire child population. The implementation of an accountable system in relation to SHS is represented in the figure below:
Figure 1. A human rights-based approach to school health services (14)

- Analyse school health data to identify priority areas, emerging health needs and ensure an appropriate budget allocation;

- Disaggregate data by sex, gender, age, urban/rural, wealth quintiles, and other variables, such as ethnicity, disability, HIV and health status to detect underlying discrimination;

- Assess the national regulatory framework for school health services, in line with the human rights-based approach to health and the Convention on the Rights of the Child.

- Develop and disseminate a school health services national strategy or policy and budget to guide programme implementation and mobilise and allocate financial resources for essential interventions with special attention to vulnerable groups of children;

- Re-organise and improve school health services, as appropriate and in accordance to new knowledge and emerging health needs.

- Put in place functioning health information systems, including data disaggregation;

- Establish a comprehensive monitoring and evaluation framework involving relevant stakeholders, including all school-aged children, school managers, teachers, SHS professionals and parents.

- Human resources, essential medicines and commodities and health infrastructure and facilities are available and accessible to all without discrimination; gender-sensitive, culturally acceptable, respectful, and protect privacy and confidentiality, and of high quality;

- Ensure an effective collaboration between SHS professionals, teachers and parents;

- Ensure health education, skills and health seeking behaviour activities;

- Support children with chronic illness, other long-term illnesses and children otherwise vulnerable.
As illustrated above, SHS must be understood in the wider context of a health system, including appropriate national regulatory frameworks (planning), the number of trained professionals, the quality of services provided and other necessary processes that are in place (implementation), as well as in the context of the functioning of Health Information Systems (monitoring and evaluation) and continuous improvement based on evidence and data (analysis).
ASSESSING SHS IN A GROUP OF NINE COUNTRIES IN THE EUROPEAN REGION

In 2020–2021, the WHO Regional Office for Europe promoted the assessment of SHS in nine countries of its region. The objective was to support countries in assessing their SHS and embark on a process for improving the quality of the services provided. This process should also help to inform similar assessments and processes in other countries in the Region and beyond.

Methodology

The overall assessment process in the nine countries was launched by WHO Regional Office for Europe and coordinated with the WHO Collaborating Centre for improving services for children based at the National Medical Research Centre for Children’s Health in Moscow (hereafter the WHO Collaborating Centre). Two international experts were also involved in the preparation of capacity-building activities and in providing technical advice to countries. Given that the assessment was carried in 2020–2021, in the context of the COVID-19 pandemic and the related travel restrictions, all support, including the capacity-building events, were carried out remotely. The only face-to-face activity prepared in the context of the project was the Final Conference, which took place in Moscow in November 2021 and was intended to serve as a platform for presenting and discussing the findings of the overall process.

Preparatory phase: development of the Assessment tool, guidance and capacity-building

The development of the Assessment tool for school health services in the WHO European Region was based on the European Framework, as well as on the principles of adolescent-friendly health services and a child-rights based approach to health. The drafting process included exchanges between the WHO Regional Office for Europe, the experts responsible for designing the tool and the WHO Collaborating Centre. The tool was reviewed and tested by WHO country staff and country experts from Uzbekistan.

In addition to the Assessment tool, complementary guidance was developed to assist country teams in carrying out focus group discussions with school principals, teachers, nurses, children of different age groups and parents.

Between August and November 2020, a series of four joint seminars were held with the participation of the nine country coordinators and, in some cases, other members of the country teams. The first two seminars were dedicated to the presentation of the tool and capacity-building, while the third and fourth seminars focused on sharing country results from the first and second phases of the process, respectively. Between November 2020 and January 2021, individual meetings were held with national coordinators, country by country. These meetings were aimed at supporting countries in the preparation of focus group discussions, as well as at understanding the findings in order to prepare the country reports.

After the assessment in the nine countries, the Assessment tool was once again revised, taking the structured feedback from national coordinators obtained through a survey, as well as qualitative feedback provided during the Final Conference, the lessons learned from the international project, and feedback from other international experts, into account.
Country teams

Each country assigned a national coordinator, as well as a team to oversee and implement the assessment of SHS in the country and carry out subsequent related work. The teams had a minimum of four and a maximum of 12 members. The coordinators and country team members were specialists in the field, including those coordinating Health Promoting Schools, Youth-Friendly Health care Services, the Health Behaviour in School-aged Children study or other relevant initiatives. Importantly, in several countries, both the MoH and the MoE were involved. Some countries also involved NGOs or WHO Country Office representatives.

Country assessment

As mentioned earlier, the Assessment tool has been designed to provide a baseline assessment for countries to understand how SHS are implemented in terms of both regulations and practices. Therefore, this is a comprehensive exercise, one which requires more effort to start with, but which is essential in order to understand what is in place, what gaps exist and, importantly, how children and adolescents benefit from existing services. These elements were taken into account when preparing a common methodology for the assessment in countries. Each step is fundamental, as it complements the information gathered and provides as clear a picture as possible.

Each participating country undertook the same steps for the assessment of SHS:

- A desk review of the SHS national legal and regulatory frameworks, including compliance with the European Quality Standards in school health services, as well as standards for children’s rights, in particular those enshrined in the CRC, and the extent to which SHS sufficiently target and address child health priorities.

- Semi-structured interviews with key informants.

- Focus group discussions with stakeholders (children, adolescents, school nurses, teachers, parents and school administration).

- An online country consultation between individual country representatives and international experts.

- Analysis of the information gathered.

Following the desk review, the participating countries chose key informants at the high level (ministries of health and education), the planning level (local health and education authorities), as well as at the local level (primary health care institutions) and carried out interviews.

Concerning the focus group discussions, country teams were specifically asked to identify a variety of stakeholders and ensure that the characteristics, perspectives and needs of different groups of stakeholders, especially children and adolescents, were taken into account. Specifically, country teams identified SHS in urban and rural or otherwise remote areas; children and adolescents of different age groups; specific vulnerabilities (i.e. children belonging to minority groups, suffering from a long-term illness, etc.), as well as those from private and public schools. Due to the COVID-19 pandemic and the associated restrictions, the national teams had to adapt their work methodologies. For example, in Kazakhstan, some questions for the school administration and all
questions for parents were adapted in an online questionnaire on Google Forms in Kazakh and Russian. In Moldova, the perspectives of children and adolescents were also gathered through an online survey. In the Russian Federation, focus group discussions, including with the school management representatives, were held both face-to-face and online.

In general, all country teams tried to take the specific features of their country into account in order to ensure that the dimensions explained above were properly represented. Annex 1 provides a summary of participating schools in each country, by region and other criteria. It also includes the total number of stakeholders, by category, who contributed to the assessment, including children and adolescents.

**Analysis and reporting**

The last step of the assessment was the analysis of information and reporting. As already mentioned, country teams received support when it came to interpreting and analyzing the data. A common template for reporting was prepared and used by each country, in order to generate comparable data. Summary tables were also prepared to register the information collected from the focus group discussions. Once again, it is important to emphasize that this was a baseline assessment. Therefore, country teams first looked at existing documentation (legislation, policies and regulations), then key informants were interviewed and, finally the teams carried out the focus group discussions to understand how services are applied in practice. This assessment at three different levels (legislation, quality of service delivery and user experience) allows us to assess the extent to which the national regulatory framework is applied in practice, to understand what is working, where there may be gaps, and the experiences of children and adolescents of the services provided. The analysis of information took these different levels into account and the final conclusions and recommendations also reflect the different perspectives.
FINDINGS

Overall SHS landscape, including financing

All nine participating countries offer SHS for free. However, in Tajikistan, only a part of services is offered free-of-cost, the remainder being paid by families with partial financial support. The availability of services varies between and within countries. Most countries cover more than 75% of public schools with SHS, ranging between 10% in Tajikistan and 100% in Kazakhstan. In most countries, SHS provision is organized differently in rural areas, and can be extremely scarce. Six countries note that they offer homogenous SHS provision across their entire territory. SHS in private schools usually follow similar rules to those applied in public schools, although with partially better staffing and/or infrastructure. Some countries report that SHS in private schools do not meet existing standards.

Only three countries mention staff-to-children ratio, which ranges from 500 to 1500 children per school nurse. Additional staff providing SHS is rare, except for dentists in Kazakhstan. However, participants noted the need for additional staff, such as psychologists, youth counselors and speech therapists. Some countries report having a specific referral system to health professionals from other specialties within the medical system.

In most countries, SHS financing is secured at the national level, with some funds coming from regional/local budgets. Some countries link financing to mandatory medical insurance, per capita. Some countries finance SHS at the local level from budgets of schools or primary health care, with the support of sponsors. Tajikistan reports a lack of financing. A number of countries consider current financing to be inadequate or insufficient, specifically as it relates NCDs (the lack of funding for health promotion and prevention).¹

Standard 1: Legal framework

Standard 1 requires an intersectoral national or regional normative framework developed by the ministries of health and education and based on children’s rights to be in place in order to advise on the content and conditions of SHS delivery.

Health and education are intrinsically linked. SHS are in a unique position to improve both health and educational outcomes by linking the educational setting with preventive health care and health promotion. In order to reach their goals, SHS need to be positioned in the legal educational and health care frameworks. Close collaboration between the educational institutions and SHS, as well as with their network towards health in the community, is needed. Effective collaboration works best when it is established in a jointly developed legal framework that strives to use synergies to inform the functioning of both settings. Such frameworks should take the CRC, as well as the Concluding Observations by the Committee on the Rights of the Child, into account.

This standard intends to explore whether specific frameworks exist, how recent they are, the extent to which they follow the CRC, and how the perspectives of both sectors, health and education, as well as the perspective of children, have been taken into account.

¹ Please see Annex 2. Overview of school health landscape in the nine countries.
All participating countries have national intersectional frameworks regarding school health in place. All countries, with the exception of Tajikistan, mentioned that these frameworks are based on the CRC. Most national frameworks have been revised in the last five to ten years, while some are currently under revision. Most frameworks were developed without the participation of children, adolescents or their caregivers. Seven countries (Armenia, Azerbaijan, Belarus, Kazakhstan, Moldova, the Russian Federation and Tajikistan) reported specifically that the framework was developed jointly by the respective ministries of health and education, with the ministry of health typically taking the lead. Moldova stated that SHS are not sufficiently reflected in the education laws.

Most of the frameworks are either specifically elaborated for SHS or have a dedicated section on SHS. The content of the decrees varies greatly, many cover the elements and standards of SHS, specifically a healthy school infrastructure, health promotion and prevention, and interprofessional collaboration. For example, Armenia has a variety of decrees explicitly describing the conditions for rendering health services in school, the content of SHS, the main principles of nurse actions, and organizational standards. The national framework of Kazakhstan, which was revised in 2020, includes decrees on health promotion, prevention, participation of parents and students, and mental health (including suicide prevention and overcoming addictions caused by smoking, psychoactive substance abuse and gambling). Moldova mentions that it has quality standards in place, some of which have been developed with the participation of children.

The Armenian report points towards the fact that the needs for a specific SHS infrastructure for children with physical disabilities are not reflected in the decrees. It also points out the lack of monitoring and accountability. Other countries emphasized the lack of specific quality standards and the need for processual regulations to be implemented: Azerbaijan stated that the country lacks a unified policy on the content and conditions of SHS delivery, and Kazakhstan reports the need to have quality standards. Uzbekistan and Armenia reported that the implementation of the decrees and standards is insufficient.

The specific legal frameworks of each country are described in the individual country reports in Annexes 4–12.

Concluding remarks concerning Standard 1

Considerable work has already been done to develop intersectoral legal frameworks specifically for SHS based on the CRC. However, the assessment identified relevant gaps and areas for further improvement. For example, frameworks could address more specifically children with special needs (impairment at the developmental, medical, psychological or behavioural level), or groups of children living in vulnerable situations. Developing frameworks with the participation of children and their caregivers would also help when it comes to adjusting existing services to the real needs of children, thus providing services of a generally better quality. SHS financing has been identified as a major challenge, therefore SHS should be appropriately regulated, including the allocation of budgets.
Standard 2: child- and adolescent-friendly health services

Standard 2 states that “SHS respect the principles, characteristics and quality dimensions of child- and adolescent-friendly health services and apply them in a manner that is appropriate to children and adolescents at all developmental stages and in all age groups. Principles of accessibility, equity and acceptability also apply to the way in which SHS engage with parents.” This standard looks at how existing services take the dimensions of child- and adolescent-friendly health services, as well as the child rights-based approach to health, into account. Specifically, this means that children’s right to information and participation in health care decision-making processes, their right to non-discrimination and the right to health as enshrined in the CRC (Article 24) are taken into account. As this standard is so closely connected to children’s rights, it is essential to gather the views of children and adolescents on how they understand, use and are satisfied with existing services.

Equity

Equity refers to the principle that SHS are to be provided on an equal basis across all schools in a given country. For example, legislation and policies stating that SHS should be provided in all schools and to all school-aged children, irrespective of their background or other characteristics, may be in place. The assessment concerning the equity dimension also evaluated the extent to which children, adolescents and parents feel that health professionals in SHS treat children and adolescents with equal care and respect. This also included adapting services to children’s needs and characteristics, as necessary.

In general, children, adolescents and parents report that they are treated in an equal manner and with respect by health professionals. Several countries mentioned specific legislation or policies in place to ensure equity. In Kyrgyzstan, according to adult and adolescent participants, “counselling is provided in the language they understood (Kyrgyz, Russian, Uzbek).” In Belarus, “foreign citizens and stateless persons permanently residing in the Republic of Belarus have the right to available health care on an equal basis with the citizens of the Republic of Belarus, unless otherwise determined by the legislative acts of the Republic of Belarus and international treaties of the Republic of Belarus.” In Uzbekistan, legislation regulating the “legal status of the citizens of the Republic of Uzbekistan, provides that children have all the rights enshrined in the CRC, including the right to non-discrimination, regardless of race, skin colour, gender, language, religion, political or other beliefs, nationality, ethnicity or social status, material situation, or health condition.” In the Republic of Moldova, “in order to ensure equity, specific policies and procedures of SHS are in place and are reflected in Quality Standards of SHS, approved by Joint Order No. 613/441 of the MoH and MoE dated 27 May 2013. SHS quality standards were developed based on existing YFHS Quality Standards in the Republic of Moldova.” In Azerbaijan, “a normative and legal framework that facilitates the access for minority, migrant and refugee children and ensures quality of care, is in place in the country.”

On the other hand, findings in Tajikistan showed that “school health services are not equal in all schools and at all levels. At present, the only adopted national document is the ‘Procedure for organizing health and preventive care in educational and child preschool educational facilities.’ The key stakeholders indicated that they had not been informed about the existence of any systems of SHS at national level.”
In Kyrgyzstan, it was also reported that “SHS in urban and regional schools have convenient operating hours, while in rural schools, children can only access care in specified hours. In urban schools, children were aware of SHS, while in rural they were not informed about the services.”

**Accessibility**

Non-discrimination is a fundamental principle of children’s rights. In terms of the child’s right to health, this means that services must be accessible physically – they must be available and in safe reach for all children and adolescents, including those with disabilities and those in other vulnerable groups – as well as financially. Financial access does not mean that services must be free, but that they should be affordable to all. Accessibility also implies the right to seek, receive and impart health-related information in an accessible format. For children and adolescents, this means that they should receive information about existing services (i.e. what SHS are available, what their working hours are, who can access them and how), on relevant health issues, as well as positive health behaviour. According to this right, personal health data should be treated confidentially as well (15).

In at least seven countries, SHS are free of charge. Concerning operating hours and waiting times, not all countries addressed the issue explicitly in their reports. According to the information that we do have, operating times and/or working hours in at least four countries are deemed to be convenient, which is not the case in at least two countries. In the Russian Federation, it was reported that “the majority of school children were informed in which cases they can address SHS and what kind of care they can receive in medical rooms. In general, the waiting time was appropriate. Almost all the children interviewed were sure that health-related information was not disclosed to third parties. First-graders represented a special group of children who did not have much experience in communication with health professionals. They said that they were afraid while visiting medical rooms; they did not understand why they were there.” In Azerbaijan, “the majority of parents (86%) participating in the focus group discussions noted that information on the services offered by the SHS and how to access them was given in schools mainly by class teachers together with school doctors; the parents were informed by their children or at special parent meetings.”

On the other hand, in the Republic of Moldova, almost 40% of adolescents who participated in the assessment mentioned that the medical office happened to be closed when they required medical assistance.” And in Belarus, “parents said that they were not interested in the hours of operation of the SHS medical rooms, as they prefer to go to their ‘own district paediatricians in the clinic or private medical centres.’” This finding from Belarus, which may not be unique to that country, points to the fact that parents may not be aware of the role and importance of SHS. In Kazakhstan, for example, the assessment showed that “the level of awareness of parents about the range of SHS available is extremely low. Only 18% of parents have ever received information about available SHS, while 82% are not informed at all.” In Uzbekistan, there were similar findings. In Azerbaijan, it was also found that “all children and parents believe that school health professionals should be addressed only in case of an emergency or pain (headache, toothache, abdominal pains). Unfortunately, children do not turn to health professionals in order to receive information or for preventive purposes, except for the specific events on promoting a healthy lifestyle.”
Acceptability

One of the dimensions of accessibility to services is acceptability, which means that health care services in place must be acceptable by those who are targeted by the services. In the specific case of SHS, for the adolescent group this can be implemented through services that ensure the respect of their right to confidential services, for example, or that ensure an environment and professionals with the necessary skills that are conducive to information-sharing, including about sexual education, violence, or other topics that may be more difficult to address. For the younger groups of children, it may mean demystifying fears related to health care or going to “doctors’ appointments,” adapting the facilities, etc.

In the great majority of countries, it was found that there are confidential services in place, including relevant policies in Belarus and Kazakhstan. Overall, adolescents and parents note that school nurses are kind and helpful. However, there are also practical conditions that prevent the right of children and adolescents to privacy and confidentiality from being respected. For example, in Armenia, “Adolescents and their parents noted that SHS staff were attentive and careful, they did not disclose information concerning adolescents to other stakeholders; confidentiality of information was guaranteed. At the same time, medical check-ups and examinations of children did not always take place in private areas due to a number of reasons: small rooms, nurses not having time, examinations taking place during lessons, etc. This resulted in adolescents feeling uncomfortable when telling nurses their private information and they were afraid that this information would be disclosed.” Similar results were found in the Republic of Moldova, where “Almost all adolescent respondents (approximately 80%) mentioned that they never feel that the school nurse is being judgemental when they communicate with her; nearly 10% occasionally feel judged, and in one case it was reported that a pupil felt constant judgement from the school nurse.” Additionally, “According to the opinion of school nurses, in almost all cases (90.6%), appointments and examinations take place in private areas. In the remaining 10% or so of cases, they indicated that this is not always possible, especially due to the lack of available areas for this. For example, nurses stated: “I can’t always respect the patient’s privacy, because I work in the same office as the school psychologist.” This opinion was confirmed by adolescents.

Participation

Participation is one of the guiding principles of the CRC and it is recognized as an essential right to help and empower children and adolescents in respect to their health. Participation may take place at two levels. At the individual level, this means being informed about what is happening to them and involving children and adolescents in decision-making processes about their own health. At the group level, this means involving children and adolescents in the assessment, design and improvement of health care services.\(^{16}\)

Concerning the participation of children and adolescents in decision-making processes regarding their own health, three countries referred to existing national legislation on the child’s right to informed consent, which specifies that children above the age of 16 (Azerbaijan and Kazakhstan) and children above the age of 14 (Uzbekistan) may give their consent to treatment and interventions. No country mentioned the possibility of assent. Although only two countries mentioned legislation, it is very likely that other countries in the region have legislation as well. Additionally, two countries provided information
that they involve children in decision-making processes at all times (Azerbaijan and Belarus), two mentioned that this was not the case (Kyrgyzstan and Kazakhstan) and in one country, one third of the nurses who responded said there was no clear procedure. Four countries did not provide any information in this respect.

Concerning the participation of children and adolescents in the assessment, design and improvement of health care services, the majority of respondents said they did not have any system in place. Two countries mentioned that this is partially implemented (Belarus and Moldova). In this regard, a promising practice was found in Azerbaijan, where the “Minor Academy” – a School Council where children of all age groups participate in decision-making in the school – has been established in Baku schools No. 177 and 202.

**Effectiveness and Safety**

This dimension assesses whether SHS professionals have the necessary competences to work with children, the adoption and use of evidence-based protocols and guidelines, and whether professionals are able to dedicate sufficient time to work effectively with children and adolescents. Additionally, it also looks at whether professionals have the necessary equipment, supplies and basic resources to deliver the services, and the protocols to assure the quality and safety of services. These elements are essential to ensuring that SHS are delivered with due regard to the most up-to-date evidence, which ensures the quality of services, but also the safety of children and adolescents. Appropriate protocols and guidelines are also crucial to ensure that unnecessary screening or other inappropriate interventions are not carried out.

Four countries mentioned specifically that SHS professionals have the necessary competences to carry out work with children. Evidence-based protocols and guidelines have been adopted at the national level in the majority of countries. In Kyrgyzstan, for example, respondents mentioned that despite the adoption of relevant protocols and guidelines, these were only available at the district level in rural areas, and that professionals generally do not have access to such guidance. Moldova also pointed out that, even though it has adopted the relevant protocols, there is no clear list of clinical protocols and guidelines to be implemented by SHS, nor is there a package of services. Three countries found that SHS professionals have insufficient time to work effectively with children (Armenia, the Republic of Moldova and Kyrgyzstan) and two countries found that there is sufficient time (Belarus and Uzbekistan). The Russian Federation and Tajikistan have not addressed these issues in particular.

In addition to the information provided above, it is important to state that some countries mentioned a number of obviously complex challenges. In Armenia, “the challenges that should be addressed include health staff being overloaded with reporting, accountability and filling log reports; the absence of medical rooms in some schools; the mandatory presence of nurses in rural and small schools; the inefficient allocation of time; the lack of counselling by nurses; the obligatory informing of adolescents and their parents on SHS services; confidentiality and information on confidentiality; providing appropriate conditions in nurse offices for children with physical disabilities; and improvement of nurses credibility and authority. In Tajikistan, “SHS professionals are not motivated [...] and do not perform their work appropriately. Health staff of almost none of the schools visited performed in-depth work on the prevention of infectious and non-communicable diseases [...] The issues of sexual and reproductive health were also poorly addressed by school health professionals. There were cases of violence. When asked about the
attitude of teachers towards them, children said that the teachers were sometimes rude and demeaning and could humiliate them in public.” In Kazakhstan, the following issue was also identified, which may be of relevance to the group of countries: “Specific conditions should be implemented for ensuring that routine screenings are periodically evaluated for their basis in evidence and applicability; non-evidence-based screenings should be reviewed.”

**Concluding remarks concerning Standard 2**

All participating countries demonstrate ongoing work and attention to many of the dimensions assessed under Standard 2, including equality, accessibility and acceptability. However, various gaps have been identified, and these must be addressed. There seems to be a misconception of SHS, about why they are there in the first place, but there also a significant lack of information on them. The assessment found variations in terms of accessibility, availability of services (including inappropriate operating hours), and insufficient time allocated. There were also issues in terms of the availability of evidence-based protocols and guidelines, as well as competencies by SHS professionals. The last two issues are of particular importance when it comes to ensuring high-quality and safe services for children and adolescents. As such, countries should pay a great deal of attention to them, even those that have already adopted legislation and relevant policy documents. One of the major gaps found in relation to children rights was the lack of attention to their right to participate in health care, both at the individual level and as a group. From these findings, it is clear that existing services need to be improved and consolidated to ensure that they are of good quality and that children and adolescents truly benefit from them.

**Standard 3: SHS facilities, equipment, staffing and data management systems**

Standard 3 requires that SHS facilities, equipment, staff and data management systems are sufficient to achieve SHS objectives (*issues of staffing and data management systems are addressed in standards 5 and 7, respectively*).

In order to guarantee state-of-the-art medical care, rooms must comply with existing environmental and cleanliness norms (including standards for dimensions, lighting, ventilation, heating and location) and must be equipped with sufficient furnishings and equipment (including properly stocked and managed emergency medications). It is important that room structures reflect the need to safeguard the right of children to privacy and confidentiality. Equipment also includes health promotion materials. Not only did the assessment look at the availability of health information materials, but it also considered how they were developed and what channels are used to reach children and their caregivers.

**Rooms**

While most countries report that there should be specialized medical rooms in schools, the reality is different in most cases: Tajikistan notes that specialized medical rooms practically do not exist in the country, except in private schools and lyceums; and only the Russian Federation reports to have adequately equipped rooms across the country, although they are understocked when it comes to emergency medications. Most countries describe a divide in the availability and adequacy of the rooms with
regard to equipment and observing environmental and hygienic standards. Overall, the situation in urban schools is better than that in rural schools. A specific problem is that confidentiality cannot always be guaranteed, specifically in those rural areas where there are no on-site nurses and nurses only make visits to schools. One country describes how the staff works hard to maintain confidentiality even under these adverse circumstances. In addition, some countries mentioned that rooms are not suitable for children with disabilities.

Most countries report having emergency medication in stock. However, the process of replenishing medicines does not always work adequately. The use of computers is rarely mentioned, and if it is, it is to note that not enough computers are available. According to one statement by professionals of school health services, the lack of digital devices means that SHS cannot work as quickly and efficiently as would be desirable – for example, in terms of referrals. As a result, parents often seek medical care in the private medical sector.

**Health promotion (HP)**

Most countries report to have nationally or regionally developed HP-material in schools and most are able to display them in waiting areas, while some also display them in other areas of the school. Some countries note that there are dedicated corners in the school where children can read books related to healthy lifestyle and health promotion. Some countries also work with children to develop their own HP-posters. However, only a few countries note that children are involved in the development of this HP-material. Many schools have HP-lectures by teachers. However, teachers do not always have sufficiently up-to-date guidance and materials for the lessons and lack specific training for health promotion. Three countries (Armenia, Belarus and the Russian Federation) mention specific health promotion websites developed in part for and by adolescents that are widely used by children, parents and teachers. In contrast, printed material does not typically interest the children. Belarus suggested looking for new ways to deliver HP materials, including websites and social media, and notes that “The materials on healthy lifestyle and health promotion that have been offered do not always arouse a keen interest among children and their legal representatives. The development of existing information platforms where such information is provided on a peer-to-peer basis can be a useful tool for maintaining health-saving behaviour.”

In addition to health promotion for and with the participation of children, the suggestion was made to include first aid and emergency care training for teachers and children.

**Concluding remarks concerning Standard 3**

According to the assessments in all countries, the awareness of the need to have specialized medical rooms is reflected in their frameworks. The reality, however, is quite different. The lack of standards regulating infrastructure for providing adequate environmental and hygienic conditions, as well as the lack of standardized processes guaranteeing the restocking of emergency medication, should be addressed. A major gap of the infrastructure is that confidentiality and youth friendliness, as stated in standard 2, cannot always be adequately guaranteed due the lack of appropriate rooms, while staff is reported to be aware of these issues. Specifically, the existing divide between rural and urban areas needs attention, with rural schools being more disadvantaged when it comes to the availability and adequacy of rooms. Another area for improvement is
reform processes, as the excessive documentation and records, complicated paperwork procedures, and lack of digital devices can hinder an effective work flow, such as the efficient referral of patients.

While health promotional materials are available in most countries, most children have never been involved in the development or in the distribution of the material. Involving youth in schools in general would help make the material more relevant for them. The proactive distribution of HP-material embedded in interactive situations, such as consultations, group lessons or other strategies could be further improved to reach a higher number of children.

In addition, state-of-the-art health promotion can be expanded through the provision by the SHS of guidance and adequate material for teachers who are leading health promotion lessons. Digital communication tools and social media are insufficiently utilized when it comes to health promotion, and countries should be encouraged to rethink their strategies accordingly. Countries might find it useful to hold exchanges with states in the region that already use such strategies.

**Standard 4: multi-stakeholder collaboration**

Standard 4 calls for the establishment of collaboration among SHS, teachers, school administration, parents and children, and local community actors (including health care providers) and for their respective responsibilities to be clearly defined.

SHS function in a close network within the school setting, as they are also linked with the health sector and the community. In order to achieve the best health results for children, robust collaboration between all these stakeholders is necessary. The rules for collaboration are, as in other settings, to take active care in establishing and maintaining these networks through clear and transparent communication, and by defining clear roles and responsibilities of each member of the network.

According to the assessments, collaboration between SHS and schools is well established in six of the nine countries. Two countries (Belarus and Uzbekistan) report an interesting model of collaboration. They have established a board of trustees as the basis of their collaboration. Uzbekistan notes that “The establishment (by decree) of the Board of Trustees is one way in which the school management and education staff support SHS. The Board consists of the selected representatives of different groups of stakeholders (children, teachers, parents, representatives of the local authorities, graduates, and representatives of the organizations that support school activity). The aims of the board of trustees include monitoring educational work in schools and contributing to the development of better conditions for such work.” In contrast, Armenia mentioned a lack of collaboration with schools, specifically that it is difficult for SHS to get time slots during lessons for their medical work with children. Moldova noted that nurses found it difficult to get accepted by the educational body for decision-making at the school level. Stakeholders reported that “[nurses] lack knowledge about educational processes”. Tajikistan reported that there is a lack of interagency collaboration at the local school level. However, the work in the context of the Schools for Health in Europe Network has, at the level of health promotion, allowed schools, SHS and parents develop a close partnership.
In most countries, schools support SHS when it comes to finding time slots to perform check-ups with children. Tajikistan specifically mentioned that schools also help find slots for health professionals to come to schools and teach children about health promotion and a healthy lifestyle. Kazakhstan and Kyrgyzstan reported that an electronic chat platform is available to facilitate communication between school and parents. The Russian Federation reported that “school websites keep contact information and medical rooms operate to a schedule. There are also special sections on the websites for children and their parents that contain up-to-date information on how to lead a healthy lifestyle and prevent infectious diseases and injuries. In addition, the websites include memos for parents and a special section for teachers with information about health lectures and lessons.”

Five countries, namely Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan and Moldova, mentioned that SHS staff is involved in developing individualized educational plans for children with special needs. Kazakhstan mentioned that this is performed within a multidisciplinary team, which includes psychologists, youth counselors, class teachers and education experts working on inclusion in schools.

In most countries, SHS staff are a resource for teachers for health promotion and in some countries, this includes structured and joint planning. In Uzbekistan, a multidisciplinary board of trustees that includes SHS staff is developing a workplan for health promotion activities. In the Russian Federation, while cooperation is in place, teachers still express the need for more recommendations and counselling by SHS staff in the context of health promotion lessons. Belarus noted that SHS also helps to support the proper sitting position by adjusting chairs to the height of children and helping tired children by taking them through eye exercises. About half of the countries report that SHS staff are involved in school nutrition and environmental health issues, such as determining hygiene standards and standards for the content of meals in the school canteen. It was also stated that this function was only in place in urban schools.

Direct communication with parents only works well in certain countries. In Uzbekistan, SHS have a special “SHS-team” that includes representatives from schools and parents. In Moldova, SHS staff participates in parent–teacher meetings. Collaboration of SHS with local community actors is not common in the participating countries. However, Kazakhstan, for example, has developed a collaboration plan based on mapping the role of local actors for child health.

Most countries report that SHS have a developed referral system. However, Kazakhstan notes that, despite this, the continuity of care is not always ensured, because children do not show up for their appointments. One reason for this is that children are referred to primary health care clinics that are not the ones they usually attend. Other barriers to referral identified were that due to lack of digital devices, referrals are too slow, and some parents seek themselves fee-for-service medical specialists. It was also found that referral is hampered by the lack of adequate specialists in rural areas.

While the overall collaboration between SHS, schools and teachers is rated rather well, collaboration with parents, health professionals and community actors is mostly rated less positively.
Concluding remarks concerning Standard 4

Collaboration between SHS, schools, teachers and parents is crucial for the effectiveness of the work of SHS on individual children’s health, as well as for the provision of quality health promotion in the school setting. In the present assessment, it was found that collaboration differs largely between countries and, on the whole, is insufficiently developed. Some countries have developed promising models of collaboration and could therefore use their experience to aid other countries in the development of their own strategies to improve their collaboration with parents, the community and the health sector. Specifically, parents are an underused resource for health promotion and future models should explore ways to get parents involved. The potential of digital communication is only used in some countries, future models should thus include these enormous possibilities. A further gap is guaranteeing the continuity of care specifically for children with chronic conditions. Close collaboration between SHS and local health care actors (including an efficient referral system) is necessary to meet the health needs of these children.

Standard 5: workforce competencies

Standard 5 requires that SHS staff have clearly defined job descriptions, adequate competences and a commitment to achieving SHS quality standards.

Well-trained and motivated staff who have clear job descriptions and sufficient time to carry out their tasks is a precondition for SHS to achieve the goal of improving health for all children. Pre-service and in-service training should be acquired by means of a regularly updated competency-based curriculum and supported by continuous professional development that includes clinical supervision. It is crucial to ensure that sufficient time is allocated for each child in order to establish trust and provide an adequate evaluation of their bio-psycho-social health. The quality of SHS increases when staff have enough time to properly perform their duties and the relevant skills to monitor and evaluate their patients and thus steer services in the right direction based on the available evidence. Allocating time for staff to update their skills and carry our research can be an additional asset for improving SHS at the national level. Staff motivation is dependent on adequate training, functional work flows, sufficient time, and on adequate salaries, among other variables.

In the assessment, almost every country noted that the job descriptions for school health staff were clear and adequate. However, such job descriptions are not available for all staff categories in some countries. As for whether staff actually carry out the work set out in the job descriptions, some countries report that this is not always the case.

Some countries have postgraduate training specifically targeted to SHS staff. For example, Moldova has a one-month course, Kazakhstan has introduced a structured curriculum for SHS staff training, and a new programme has been launched in one Russian city. Recruitment protocols are in place and offer continuous medical education with a recertification process. For example, Kazakhstan offers structured training and recertification. Some countries mentioned that EUTEACH Training (European Training in Effective Adolescent Care and Health) has been offered, with those who have completed the course saying it was useful.

Four countries (Azerbaijan, Belarus, Kazakhstan and Moldova) mentioned that SHS staff have access to up-to-date information. Moldova reported that SHS staff have access to such information in at least parts of the country. An example of a good practice is the
internet platform offered for SHS staff in Moldova.

Some countries mentioned that supervision and feedback is offered to SHS staff, specifically in Health Promoting Schools. Kazakhstan has implemented the systematic monitoring of SHS Health Promoting Schools, where territorial coordinators are paid for monitoring activities.

Regarding the workforce, only a few countries reported that they had multidisciplinary professionals working in schools. Mental health professionals, for example, are rarely available in SHS. Six countries provided a workforce ratio, indicating an average of approximately 1 school nurse per 500–700 children (ranging between 1 school nurse per 390 children in some regions in Kazakhstan to 1 school nurse per 1500 children in Kyrgyzstan). Similar to what was found for other standards, a difference was identified by countries concerning the workforce ratio between urban and rural SHS, where workforce resources in the latter tend to be lower.

Low staffing results in a high workload. The assessment also found that the problem of not having enough time to properly carry out one’s duties is further exacerbated by the inadequate content of the work and ineffective administration.

Low motivation of SHS professionals has also been identified as a significant issue in many countries. Reasons for this include lower salaries than in comparable jobs in primary or hospital health care, underappreciation of their work, limited opportunities for professional development (i.e. insufficient time and lack of incentives), and the fact that SHS staff occupy lower positions than teaching staff in the school hierarchy. Discrimination of the school nurse was even mentioned as a contributing factor. A knock-on effect of the low motivation among SHS staff is that these positions are predominantly occupied by older people in many countries.

Concluding remarks concerning Standard 5

While clear job descriptions for SHS-staff are in place in most countries, there are major gaps in adequate staffing of SHS. Existing standards of workforce ratios are often not met, specifically in rural areas, thus endangering the quality of work. In addition, the resulting work overload adds to the often-described low motivation of staff, which is also a consequence of poor salaries. There is great diversity in terms of appropriate pre- and in-service training, which is a precondition for quality services. In order to achieve the goal of improving the health of all children, countries need to create conditions for the adequate training, recruitment and retention of skilled SHS staff.

Standard 6: service packages

Standard 6 requires calls for the creation of a package of SHS services that is based on priority public health concerns and supported by evidence-informed protocols and guidelines. The service package should encompass population-based approaches, including health promotion in the school setting, and services based on individual needs.

It is extremely important that the content of the service packages is in line with the health promotion and health care needs of each country. For this reason, it is vital to
have country-specific evidence-based epidemiology that can be used to define priority health problems that need to be tackled both at the level of health promotion and at the level of health care, including early identification and intervention. Early identification is supported by screening. However, effective screening has clearly defined rules and evidence-based criteria. Non-evidence-based and ineffective screening practices should be abandoned, since it wastes resources that are otherwise urgently needed. Additionally, inappropriate screening practices can cause negative consequences for individuals, including stigmatization. SHS service packages should be an integral part of the national health care system and complement it adequately. Therefore, the content of SHS services packages may differ substantially between countries.

**Screening**

In the present assessment, eight out of the nine participating countries provide a wide range of services for screening physical and developmental pathologies for all children. In some countries, screening is also performed for mental health-related conditions. Services encompass early identification, treatment, referral and prevention of infectious diseases and some NCDs. Services are based on government decrees.

All countries offer eye examinations and hearing tests. Further screening practices differ widely between countries. For example, while some countries do not perform any kind of screening for musculoskeletal conditions, Kazakhstan performs extended screening for orthopaedic deformities such as full plantography, which involves a full-scale screening analysis of the status and biomechanics of the musculoskeletal system. Armenia offers screening with a pelvic ultrasound to every adolescent girl.

**Sexual and reproductive health services**

Most countries do not provide sexual and reproductive health services beyond counselling (e.g. availability of contraception including condoms, screening and referral for sexually transmitted infections). It is important to note that the majority of countries did not address these issues during the focus group discussions held as part of the assessment, because the coordinators found it difficult or inappropriate.

**Vaccination**

SHS in most countries offer vaccinations and report high vaccination rates.

**Other issues reported**

Other challenges have been reported concerning SHS services. For example, there is a scarcity of services regarding the identification and follow-up of mental health conditions, including substance use; the needs of children with physical disabilities or those with chronic conditions are only partially addressed within the services packages by countries; and continuity of care is not guaranteed in some countries. Concerning the latter, it was reported that referral does not work properly and sometimes children do not show up at the intended places. Individual health status information often does not reach the school health professional. Finally, as already reported in other standards, SHS in rural areas tend to offer less services.

---

3 Please note that Tajikistan did not provide any information on this aspect.
**Concluding remarks regarding Standard 6**

A wide array of services is offered across all countries. High vaccination rates underscore the work done by SHS to reach all children with preventive measures for infectious diseases. However, while countries state that there is an evidence-base that supports the need for all the specific services offered, NCDs, such as mental health and sexual and reproductive health are not addressed sufficiently. In addition, it would appear that several screenings and interventions are not based on public health concerns or any robust evidence, or are outdated. An additional finding seems to be that the amount of time dedicated to infectious disease control and administration is not proportionally adequate to the time allocated to NCD-prevention. The needs of children with physical disabilities or those with chronic conditions are partially addressed within the services packages.

**Standard 7: data management systems**

Standard 7 stipulates that a data management system that facilitates the safe storage and retrieval of individual health records, the monitoring of health trends, the assessment of SHS quality (structure and activities) and research be available.

Health services need to document the health status of each individual and interventions that have been performed. If a child needs to be referred to other health providers, this data needs to be transferred to the next health provider, in accordance with the consent policies in place in the country. In modern health systems, this information is also made available to the patient as the owner of the information. In the case of SHS, these are the parents or the children with decisional capacity, according to the law of the country. Today, electronic data management systems are increasingly used for this purpose. Electronic systems facilitate the transfer of data and the establishment of registers and support the autonomy of patients. However, electronic data management systems need additional attention and precautions to be securely protected. Data from the health services can also be used anonymously for the purpose of monitoring health trends and thus designing adequate interventions. In addition, they can be utilized to evaluate the SHS quality and thus support the development of the services, including in terms of continuous improvement. Data should also be used to advance the scarce research regarding SHS, thus adding to the body of knowledge and the appreciation of the work done by SHS. However, it is important that only meaningful data is collected, and that indicators are clearly defined and are used across services with the same criteria and definitions.

Data management systems

Almost all countries maintain data management systems that comply with data protection requirements. Access to individual children’s health information is permitted and could be used for reporting and informing the decision-making process at the policy level. Tajikistan does not have a data management system. Moldova reported that there are no protocols for data protection in place.

Some countries reported specifically that their data management systems enable referrals and continuity of care. Armenia, Azerbaijan, Kazakhstan, the Russian Federation and Uzbekistan have started developing or already have an electronic health information system in place. In Kazakhstan, an electronic health information system has been developed for primary health care, and approximately half of the country’s SHS have

---

4 For related information, see Standard 2, under the participation section.
access to and work with this system. The same has been reported by the Russian Federation, which has a unified digital health system, although only approximately 50% of SHS in the country have access to this system. In Azerbaijan, SHS staff do not have computers to access and work with the existing system. The issue of the lack of electronic devices, as well as unreliable internet connections is mentioned by other countries too.

**Monitoring health trends and carrying out research**

A wide variety of health data is collected and various registers are maintained. Moldova listed more than 30 School Health registers. Some unified indicators such as somatic data (e.g. weight, height, the existence of chronic conditions) and infection control (e.g. vaccination data) are used. While a few countries periodically provide reports on health status, communicable and non-communicable diseases, as well as on public health priorities and emerging health trends, only Kazakhstan and Uzbekistan explicitly reported using SHS data for public health research.

**Concluding remarks on Standard 7**

Paper-based data systems that allow the management of individual health records are mostly in place in the countries assessed. However, the use of electronic data management systems is not widespread. Where they are in place, their use is hampered by the lack of electronic devices in the SHS, and in some countries by unreliable internet access.

Collected data, specifically when only paper-based, is not sufficiently used for monitoring the quality of health services, identifying health priorities and supporting public health research. Many different forms and indicators are used; however, these are not harmonized within the regions of respective countries and are of questionable use. Too many registers with unclear benefits are established. These findings underscore the fact that unified electronic data management systems should be developed in order to improve the quality and efficiency of SHS. Protocols for guaranteeing data protection are necessary. Electronic systems should be able to interact with the electronic systems of other health care providers and institutions to support referral and continuity of care. Data should be used for quality improvement, steering the SHS, identifying health priorities and contributing to public health research.

**Current Challenges for SHS**

The final section of the Assessment tool focused on existing challenges that school health services experience in the respective countries. Given that the assessment took place in the context of the COVID-19 pandemic, three extra questions were added, namely: overall challenges specifically related to the pandemic; major concerns about COVID-19 and SHS; and the provision of new services during COVID-19.

Despite the tailored question, in this section country reports, mostly countries reported the challenges that had been described in the sections above. We will thus only talk about additional challenges or issues that require specific attention here.

1. Essential infrastructure is not always guaranteed in the participating countries. For example, Tajikistan is struggling with the availability of drinking water in schools and the low temperatures in medical rooms in the rural areas.
2. The absence of a clear coordination and supervisory body of SHS at the district and national levels challenges some SHS.

3. Regarding the service packages offered, countries are lagging behind on age-appropriate sex education.

4. Most countries report a striking difference in the availability of services, infrastructure and quality between urban and rural areas.

5. In several countries, the perspectives on SHS differed greatly between SHS staff, users of the services (including adolescents and parents), educational staff and other stakeholders, indicating a lack of shared understanding and adequate communication.

6. Schools, communities and health care professionals outside SHS are often not aware of the important role of SHS for the health of children and adolescents. In addition, children often lack appropriate knowledge about the prominent role of health in their lives.

**Action points**

The assessment of SHS provides comprehensive information about the seven standards identified and how these are implemented in the nine participating countries. Planning efforts and the improvement of existing services should be informed by best practices and the gaps identified in each country. The action points presented here are based on the overall results; however, each country should look carefully at its individual results including, importantly, looking at the feedback from the focus group discussions and surveys of children, adolescents, parents and school and SHS professionals.

**Standard 1: legal framework**

Considering the important role of a legal framework for the effective functioning of SHS, legal frameworks should be supplemented with regulations on how standards are implemented (guidelines, standards, content, evidence-based clinical protocols, standardized qualification requirements and job descriptions) as well as provisions on accountability and monitoring. Frameworks should be developed specifically for comprehensive SHS and take the CRC into account. Normative regulations should be in place for medical rooms and should include a developmental perspective (i.e. adequate rooms for all ages). Decrees should cover the content of SHS, including health promotion and prevention, basic mental health, SRH and chronic condition care services, etc. Due to the burden of NCDs, decrees on SHS financing should include appropriate earmarking for preventive health care and health promotion. The legal framework should specifically address services for children with special needs (i.e. developmental, medical, psychological or behavioural impairment) or vulnerable population groups. When undertaking any revisions of the legal frameworks, children, adolescents and their parents/caregivers should be consulted and participate in the development of relevant frameworks. In addition, intersectoral collaboration should be improved, for example by developing inter-agency decrees on organizing health and social care for children in educational facilities regardless of the ownership type, and by regulating the relationship between health professionals and school administration in collaboration between the ministries of health and the ministries of education. Specifically, the (health) educational role of SHS staff (namely nurses) should be reflected in decrees on education.
Standard 2: child- and adolescent-friendly services

First, it is important to emphasize the need to ensure that all children benefit from national legal frameworks on SHS equally, including those living in rural and urban areas. These should include standards for child- and adolescent-friendly services, a framework of competencies for SHS professionals and the adoption of evidence-based protocols and guidelines, which should be made known and available to all relevant professionals. Second, greater attention must be given to the principles of child- and adolescent-friendly SHS at the practical level, including awareness raising of all stakeholders involved, such as policy-makers, school principals, teachers, SHS professionals, children and adolescents and their parents. It is important to clarify the role of SHS and inform children and parents alike about existing services, how they can help children and adolescents and how to access them. Finally, friendly SHS essentially mean that services are adapted to the needs and characteristics of children and adolescents, and while some interventions may require financial resources (for example, equipment), others (for example, respect for privacy, providing confidential services, informing children, involving them in the health care decision-making processes and treating children and adolescents in a respectful manner) do not require additional financial resources. Listening to children and adolescents and learning from their experiences will also help countries to improve their services and address gaps in a more effective manner.

Standard 3: infrastructure (rooms and health promotion material)

Regarding rooms, sufficient resources should be allocated to implement the standards across the countries, both in urban and rural regions and throughout all institutions at all educational levels. In addition, sustainable processes for replenishing material, including medications, need to be in place. Standards for specialized medical rooms in schools should not only be in place but – where not already done – supplemented with standards regulating infrastructure, environmental and hygienic conditions, emergency medication stocks and confidentiality. Other aspects based on child- and adolescent-friendly health care, as described under Standard 2, should also be taken into account. Regarding health promotion, countries that have not yet done so should develop updated material. Since teachers play an important role, they should be provided with guidance on how to deliver health promotion lessons. An effort should be made to ensure the participation of children and adolescents in the development of health promotion materials at the national, regional and local levels.

Strategies should be developed to ensure that health promotion materials reach children and parents, for example by finding new and/or effective ways of dissemination and awareness raising, including through websites and social media. The potential of electronic media should be considered, as it helps save resources, update information on a regular basis and better reach the target audience. If structured in an interactive way, electronic media can also produce better learning effects. Since several countries in the European Region already have websites for health promotion, an exchange between countries and using synergies could also help advance health promotion in a resource-saving manner. Digital strategies should complement and not replace the distribution of HP-related material embedded in interactive situations, such as consultations, group lessons or by other means, to take place in all schools.
Standard 4: collaboration among SHS, teachers, school administration, parents and children and local community actors

Since collaboration between stakeholders at the school and community levels – with parents/caregivers and the local health care system – is crucial for the fulfilment of the goals of SHS, it is important to develop models of participation and of multidisciplinary collaboration within this network. SHS should develop plans on how to improve communication and collaboration with parents, health professionals and community actors and periodically evaluate feedback for further improvement.

Collaboration between SHS, schools, teachers and parents could benefit from a structured approach, for example, through systematic meetings. Good examples, such as the creation of a board of trustees for SHS, schools and parents should be explored further. Another approach could entail schools supporting SHS by offering time slots and transmitting information to parents. Electronic communication tools should be explored for their potential and a structure of systematic electronic information should be developed. Electronic systems should also be available to ensure effective referrals. Past referrals should be evaluated in order to identify and improve factors that impede the continuity of care.

Regarding health promotion, SHS and teachers should collaborate closely to develop and carry out health promotion activities. The motivation of parents and children to contribute to health promotion should be used as a resource and related participative processes should be developed.

With public schools becoming increasingly inclusive, the issue of care for children with physical disabilities should be resolved through the development of tools for active collaboration, the integrated assessment of needs, and the referral of children. In this regard, it is important to develop mechanisms to coordinate the work of all involved specialists at the school and community levels. SHS should be closely involved and staff should be given the appropriate training, where necessary.

As with other standards, a general recommendation would be to develop specific strategies to overcome the divide in the functioning of SHS (including collaboration) between urban and rural areas.

Standard 5: SHS staff

Four areas can be improved in relation to this standard. The first concerns competent and properly trained staff. Unified training programmes (undergraduate, postgraduate and continuous medical education) for SHS staff should be developed and timeslots should be secured for training staff to address priority health problems, including up-to-date knowledge and skills. Concerning workforce ratio and multidisciplinarity, standards for workforce ratios should be defined where this has not yet been done and mechanisms and resources should be in place to implement the ratios across the country. A multidisciplinary approach should be considered when establishing SHS teams, including school nurses, medical doctors (paediatricians and general practitioners), mental health specialists, nutrition specialists and physical education specialists. For all necessary specialists from disciplines not included in SHS staff, an adequate, low threshold referral system should be established. Third, it is important for countries to address the issue of job satisfaction and motivation. In order to hire adequately trained and motivated staff, it is important to secure appropriate budgets for SHS staff salaries that are comparable
to salaries in primary health care. In addition, professional development for SHS staff (programmes, financing, time slots) needs to be established within the services. In order to improve the image of SHS staff, schools and parents need to be informed on the importance of SHS. This approach may work best by implementing a collaborative process focusing on health, such as the Health Promoting Schools initiative. Finally, it is important for countries to ensure the quality of services, in addition to curriculum-based training, as mentioned above. There is a need to develop and implement recruitment protocols, provide supervision and feedback for staff, ensure conditions for SHS staff to carry out research activities and develop additional systematic mechanisms for quality assurance, such as recertification and monitoring.

**Standard 6: the SHS service package**

In order to address the health needs of children while striving to ensure the efficient use of resources, it is important to carefully define and regularly (re-)evaluate the national and local public health priorities that should be addressed by the interventions of SHS. Second, where it has not yet been done, SHS interventions should be built on evidence-based protocols and guidelines. These should be developed and regularly updated in terms of the content of service packages to be delivered. This is specifically applicable to SHS screenings, where a system for regular assessment should be in place to ensure that screenings are necessary and evidence-based. Non-evidence-based screenings should be revised or abandoned.

Given that the incidence of non-communicable diseases is increasing in this area of the European Region, it would be a good idea to expand sexual and reproductive health services, as well mental health services (including those related to substance use), where necessary.

Maintenance and improvement of service quality should be periodically evaluated, including looking at issues such as whether age-appropriate patient confidentiality is ensured and monitoring patient satisfaction. As for other standards, it is important to ensure quality services across the country, including in rural and other isolated areas.

**Standard 7: data management systems**

Paper-based data systems that allow the management of individual health records are mostly in place. However, the use of electronic data management systems is not widespread. Where they are in place, their use is hampered by the lack of electronic devices in the SHS, and in some countries by unreliable internet access. Collected data, specifically when only paper-based, is not sufficiently used for monitoring the quality of health services, identifying health priorities and supporting public health research. Many different forms and indicators are used; however, these are not harmonized within the regions of respective countries and are of questionable use. These findings underscore the fact that unified electronic data management systems should be developed in order to improve the quality and efficiency of SHS. This includes developing protocols for guaranteeing data protection. Electronic systems should be able to interact with the electronic systems of other health care providers and institutions to support referral and continuity of care. Data should be used for quality improvement and steering SHS, as well as for identifying health priorities and contributing to public health research.
While paper-based data management systems are in place in most countries, they can hardly fulfil the requirements of modern data management, which provides easy and timely access to individual health records, and meet the criteria for supporting referral and data exchange, as well as providing a data basis for monitoring health problems. We thus recommend that a national adaptable Health Information System (HIS) for SHS be developed that can interact with the HIS of other health care systems in the country and that fully respects data protection requirements. To ensure that the HIS functions properly, it is important to provide the necessary number of electronic devices that SHS staff can use directly in their place of work and ensure stable internet access. Regarding the evaluation and steering of services, a process of periodic analysis of data collected should be established in order to inform the continuous development and adjustment of SHS in addressing health priorities and for monitoring quality. Existing registers should be reviewed and reduced to a necessary minimum, in order save the already scarce resources and thus enable SHS staff to spend their time on relevant clinical, counselling and administrative work. Finally, SHS should be allowed to contribute to public health research. As a basis, a unified set of indicators relevant for individual and public health that allow for comparability of data from various health care systems should be developed.
CONCLUSION AND NEXT STEPS AT THE COUNTRY LEVEL

A Final Conference was held in Moscow on 18–19 November 2021 with the participation of representatives from the nine participating countries to exchange views on the findings and discuss the way forward.

The specific objectives of the conference were to:

- Review findings from the assessment in the nine project countries, including areas of improvement identified, and learn about examples of good practice;
- Review experiences concerning the use of the Assessment tool in order to improve it for further use in the WHO European Region;
- Agree on main recommendations;
- Discuss next steps in project countries.

Next steps identified at the country level

During the conference, the participating countries presented an initial overview of the next steps that had been envisioned. These included launching an intersectoral and stakeholder dialogue based on the results of the assessment. The dialogue produced the following goals: improving the quality of SHS by strengthening the legal framework and financing of SHS; defining and adapting standards for SHS quality and staff competencies; and preparing guidelines for implementation and related monitoring and evaluation. Some of the country-specific steps identified include:

- Belarus plans to launch a continuous feedback system on the performance of SHS;
- Azerbaijan plans to carry out a survey on child health and on the role of SHS;
- Kazakhstan plans to develop algorithms for health care provision;
- Moldova plans to strengthen the links between PHC and SHS; and
- Armenia plans to develop a child and adolescent strategy and engage children in that process.

Digitalization based on a normative framework was mentioned as a major issue that needs to be addressed. Specifically, plans include either developing modules for SHS within a national health information system or guaranteeing compatibility between the existing electronic databases of SHS and local PHC.

SHS staff training is seen as another major step towards improving the quality of care provided. Plans are to revise the educational programmes for nurses and doctors in the primary health care system (Armenia), include School Health Care in public health educational programmes (Kazakhstan) and introduce issues of adolescent health (i.e. non-communicable diseases such as substance use, sexual and reproductive health, and specific methods such as motivational interviewing) by, for example, organizing an EUTEACH course.
A variety of learning formats was proposed, from lectures, workshops, conferences to distance learning. Kazakhstan plans to develop a roadmap for the capacity-building of SHS staff.

As for improving health education and promotion, it is planned to update materials and find or intensify new approaches: developing electronic platforms, supporting teachers in their health promotion role with materials such as guidelines and training courses. Belarus plans to increase the involvement of students and parents in Health Promotion, while Uzbekistan is drafting a law on bullying.

Support needed from WHO for the next steps

During the meeting, countries expressed the need for further support from WHO. First, WHO is expected to assist in translating and publishing the assessment reports. Technical and financial support is desirable for the preparation of the stakeholder dialogue, the revision of the legal framework, research into the efficiency of preventive interventions, including medical check-ups and screenings, and financial assessments. Countries also call for WHO’s support in the development of electronic data management systems and staff training with a focus on effective health promotion and adolescent health. Regarding the improvement of health promotion and education, WHO is called up to support the development of effective approaches, including the development of electronic information platforms, the use of social media, and updating materials. Other specific proposals for WHO support including facilitating the exchange of experiences among SHS in the Central Asian Region and studying best practices in the European Region.

Revision of the Assessment tool

A short survey was developed to get feedback from the countries regarding the usefulness of the Assessment Tool, the appropriateness of the assessment process and the guidance provided for completing it, as well as to elicit suggestions for further improvement. Five countries, namely Belarus, Kyrgyzstan, Moldova, the Russian Federation and Uzbekistan, responded to the survey, while the other four countries confirmed that the Assessment tool had a clear overall structure, appropriate format, clear language and terminology and referred to previously known SHS standards. Moldova indicated that the tool was too demanding in terms of the effort needed and stated that it should be improved by eliminating redundancies and using a template in Excel or similar format. The first comment was taken into account and the Assessment tool was checked and revised to delete redundancies.

The Russian Federation suggested creating focus groups to separate young adolescents (10–14 years old) from the older age group (15–19 years old), as well as to separate children according to gender in the older group. In addition, the Russian Federation proposed leaving out sensitive questions regarding sexual and reproductive health (contraception and STIs).

Regarding the process, the four countries mentioned reported that they appreciated the capacity-building workshops as particularly helpful and indicated that the guidance for implementing the tool and carrying out the necessary discussions was sufficient and adequate. In contrast, Moldova indicated that the process was not sufficiently clear from the beginning and that the focus groups could not be created in the country, so quantitative assessments were performed instead. As for the first comment, this

---

5 See Annex 3 for the complete survey applied.
project served to pilot the Assessment tool and support the country. As a result, efforts were made during the process to tailor the support to specific needs, which may account for the fact that some representatives felt that the process was not laid out in detail from the very beginning.

**Next steps planned by the WHO Regional Office for Europe**

In the future, the WHO Regional Office for Europe plans to continue offering technical support to countries to finalize and publish national reports and initiating national policy dialogues with major stakeholders in order to find consensus on policy and services improvement. In addition, support will be given for the development and implementation of national action plans.

At the European level, the WHO Regional Office for Europe intends to publish a package of updated assessment tools and to support the wide dissemination of the tools and lessons learned from the project.

Nine countries successfully participated in the process of assessing their SHS as a basis for further improvement. This comparative report gives an overall picture of the nine assessments and summarizes action points for the whole region. The assessment reports of each of the countries identify major strengths of their SHS, as well as areas of further improvement in accordance with the standards of the European Framework for quality standards in school health services. Participating and other countries may be guided by these findings to prepare national strategies or action plans, a review of the national regulatory framework or other interventions, as appropriate and necessary to improve SHS for children and adolescents in their settings.
REFERENCES*


* All references were accessed 25 August 2022.
### Annex 1. Number of schools engaged per participant country

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of schools by region and other criteria</th>
<th>Total number of stakeholders who participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armenia</td>
<td>10 schools in four regions (marzes) were selected for the assessment: Armavir, Yerevan, Syunik and Shirak. In two districts, the assessment was conducted in urban and rural schools; in one district it was conducted in rural schools only; and in the capital city (Yerevan) it was carried out in public and high schools.</td>
<td>86 adolescents aged 13–16 (54 girls and 32 boys) participated in focus groups discussions and online surveys</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>The Ministry of Education selected 25 schools to participate in the assessment. The sampling was based on the following considerations: economic and geographic factors; schools with large and small numbers of pupils; as well as city/district/rural area. Two schools from each of the nine economic regions were selected. Seventeen schools from districts and rural areas, six schools from the city of Baku, and two each from the city of Sumgait and the Absheron district of Baku were selected. Among the six Baku schools were four Health Promoting Schools, one lyceum, and one school with inclusive education.</td>
<td>Focus group of schoolchildren: 570 Focus group of specialists: 72 Focus group of school administration and teachers: 250</td>
</tr>
<tr>
<td>Belarus</td>
<td>All regions of the country were included in the Assessment: Brest, Vitebsk, Gomel, Grodno, Minsk and Mogilev regions, and the city of Minsk itself. Two private schools in Minsk also participated.</td>
<td>102 health professionals 21 teachers, school psychologists and school administration staff 498 legal representatives of children, 926% of whom (450 participants) were from urban areas, and 74% (36 participants) were from rural areas 463 children aged 6–9 513 children aged 10–14 and 625 children aged 15–18</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>Participants from four regions (27.9% of whom lived in urban areas, and 72.1% of whom lived in rural areas): Atyrau Region (31.3%), East Kazakhstan Region (26.7%), Nur-Sultan (22%) and Kyzylorda Region (19.9%). Five of the schools were urban, three were regional, four were rural, and two were private.</td>
<td>Representatives of school administrations: 151 Children aged 6–9: 129 Children aged 10–14: 131 Adolescents aged 15–18: 111 Parents: 383</td>
</tr>
<tr>
<td>Country</td>
<td>Number of schools by region and other criteria</td>
<td>Total number of stakeholders who participated</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>Five regions of the Kyrgyz Republic (Chuy, Naryn, Talas, Osh and Jalal-Abad) and Bishkek City.</td>
<td>Children aged 8–11: 163</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Children aged 12–18: 158</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School administration and teachers: 159</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents: 165</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health professionals: 113</td>
</tr>
<tr>
<td>Republic of Moldova</td>
<td>314 schools from all territorial units participated in the study (near one quarter of all schools in the country), including rural, district, town and city schools. Two parents (1.7%) indicated that their children had special educational needs and 11 (7.5%) stated their children suffered from chronic conditions.</td>
<td>881 representatives of school administration and teachers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>238 school nurses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>147 parents, mostly mothers (96%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>207 adolescents between the ages of 14 and 19</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>Public educational facilities in Moscow, Moscow Region (Ramenskoye, Dolgoprudny, Ilyinskoye-Usovo), Yekaterinburg, Sverdlovsk Region, Siberian Federal District (Mezhdurechensk, Osinniki, Novokuznetsk, Novosibirsk, Tomsk) and Southern Federal District (Rostov-on-Don).</td>
<td>Children aged 6–9: 81</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Children aged 10–19: 123</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents: 165</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SHS professionals (health professionals of the departments of child health): 20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School management and teachers: 18</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>Four regions and 10 districts were selected for the assessment. Both municipal and rural schools, as well as schools with migrant and refugee children (mostly from Afghanistan), national minorities (Lyuli – the local Roma population) and schools located in remote mountain regions were assessed.</td>
<td>Children: 1275 (525 from urban schools and 750 from rural schools)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents: 200</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School principals: 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deputy principals: over 34</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teachers: 330</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School health professionals and health staff of the PHC: one staff member of the Innovation Lyceum (Dushanbe, private school) and 14 PHC employees assigned to schools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Representatives of the community: 45</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Representatives of sole proprietorship companies (including school canteens): 60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Representatives of the UN agencies, FAO, WFP, WHO, UNICEF, UNFPA, Aga Khan Foundation, etc: 12</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>12 schools were selected to participate in the assessment by the joint decision of the MoH and MoE. Three schools in the city of Tashkent (two state and one private); three schools each in Ferghana, Tashkent and Qashqadaryo regions (one urban and two rural in region). The sampling of schools was carried out with account for their geographical diversity (urban and rural areas) and organizational diversity, representing state and private schools.</td>
<td>Focus group discussions were held face-to-face while visiting the selected schools In total, 494 representatives of key stakeholders participated in the assessment</td>
</tr>
</tbody>
</table>
### Annex 2. Overview of the School Health Landscape in nine countries

<table>
<thead>
<tr>
<th>SHS Landscape / Country</th>
<th>Armenia</th>
<th>Azerbaijan</th>
<th>Belarus</th>
<th>Kazakhstan</th>
<th>Kyrgyzstan</th>
<th>Republic of Moldova</th>
<th>Russian Federation</th>
<th>Tajikistan</th>
<th>Uzbekistan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model of Service provision</strong></td>
<td>SN from PH Facility in Schools, FT/PT, SPMR. Rural: no MD. Responsibility at territorial level. Homogeneity across the country.</td>
<td>HP in school FT/PT, SPMR. (Health unit one per school except small schools, where services were provided by PHC Facility). Otherwise, homogeneity across the country.</td>
<td>HP in school FT/PT, SPMR. (Health unit one per school except small schools, where services were provided by PHC Facility). Otherwise, homogeneity across the country.</td>
<td>HP in school. SPMR not always there, rural schools without service (then provided by other health actors). Heterogeneity across the country.</td>
<td>HP in school FT/PT, SPMR. Homogeneity across the country, but different time resources of staff.</td>
<td>HP in school FT/PT, SPMR. Rural/small schools: Service by PHC-facility. Otherwise homogeneity across the country</td>
<td>HP in school or PHC Facility (if available). No more information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SHS Coverage of schools in the country. All ages, including Kindergarten</strong></td>
<td>76–100% (as by standard)</td>
<td>76–100%</td>
<td>100%</td>
<td>(-)</td>
<td>&gt;91% (urban 99%, rural: &gt;88%). 57% in primary care institutions</td>
<td>76–100%</td>
<td>Approximately 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type of additional staff</strong></td>
<td>Psychologists, speech therapists, youth counselors (envisioned)</td>
<td>Psychologists, speech therapists (in inclusive schools)</td>
<td>Referral system (incl. ENT, dentist, psychologist)</td>
<td>Dentist, social care, psychologist. Territorial SHS coordinator for monitoring SHS improvement.</td>
<td>Collaboration in capital city with youth counselor, psychologist, teacher, juvenile affairs inspector.</td>
<td>Counsellors</td>
<td>Counsellors Referral available for children with special health care needs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*SHS = School Health System, FT = Full Time, PT = Part Time, SPMR = School Public Health Replication, PH = Primary Health, MD = Medical Doctor, SN = School Nurse*
## Workforce ratio*

<table>
<thead>
<tr>
<th>Country</th>
<th>Armenia</th>
<th>Azerbaijan</th>
<th>Belarus</th>
<th>Kazakhstan</th>
<th>Kyrgyzstan</th>
<th>Republic of Moldova</th>
<th>Russian Federation</th>
<th>Tajikistan</th>
<th>Uzbekistan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 SN/700 pupils</td>
<td>1 SN/1000 pupils</td>
<td>1 SN/700 pupils</td>
<td>Standard: 1 SN/500 pupils (including Kindergarten)</td>
<td>1 MD/2500 pupils</td>
<td>1 SN/476 pupils</td>
<td>(-)</td>
<td>(-)</td>
<td>(-)</td>
</tr>
<tr>
<td></td>
<td>1 MD/1800–2500 pupils</td>
<td>1 MD/1200 pupils</td>
<td>1 MD/1800–2500 pupils</td>
<td>Reality: 1SN/539 pupils (range 370–1096)</td>
<td>1 MD/1200 pupils</td>
<td>(-)</td>
<td>(-)</td>
<td>(-)</td>
<td></td>
</tr>
</tbody>
</table>

## Private schools

<table>
<thead>
<tr>
<th>Country</th>
<th>Armenia</th>
<th>Azerbaijan</th>
<th>Belarus</th>
<th>Kazakhstan</th>
<th>Kyrgyzstan</th>
<th>Republic of Moldova</th>
<th>Russian Federation</th>
<th>Tajikistan</th>
<th>Uzbekistan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Free to decide (mostly with MD + SN)</td>
<td>Similar to public schools</td>
<td>Similar to public schools</td>
<td>Similar to public schools</td>
<td>Heterogeneity (from very well equipped and staffed to absent)</td>
<td>Similar to public schools, but “superior working conditions”</td>
<td>Mostly MD and nurse. SHS standards only met in urban areas.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Financing

<table>
<thead>
<tr>
<th>Country</th>
<th>Armenia</th>
<th>Azerbaijan</th>
<th>Belarus</th>
<th>Kazakhstan</th>
<th>Kyrgyzstan</th>
<th>Republic of Moldova</th>
<th>Russian Federation</th>
<th>Tajikistan</th>
<th>Uzbekistan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service free. National resources, budgeting at national, regional and local levels.</td>
<td>Service free. National resources, budgeting at national, regional and local levels.</td>
<td>Service free. (incl. dental and social care). National resources, budgeting at national, regional and local levels.</td>
<td>Service free. (incl. dental and social care). National resources, budgeting at national, regional and local levels.</td>
<td>(-)</td>
<td>Service free. State budget (per capita, according to mandatory medical insurance). Funding does not meet volume, and insufficient funding for HP/Prevention</td>
<td>Service Free. State budget (per capita, according to mandatory medical insurance). Funding does not meet volume, and insufficient funding for HP/Prevention</td>
<td>Service Free. Infrastructure financed by schools, staffed by territorial PHC, plus sponsors.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Salaries regulated by decree.</td>
<td>Service free.</td>
<td>(-)</td>
<td>(-)</td>
<td>(-)</td>
<td>(-)</td>
<td>(-)</td>
<td>(-)</td>
<td></td>
</tr>
</tbody>
</table>

*Data on types of staff and on workforce ratio are supplemented with information given in Standard 5 (staffing)

### Abbreviations

- **FT/PT** = Full Time/Part Time
- **HP** = Health Professional
- **MD** = Medical Doctor
- **PHC** = Primary Health Care
- **SN** = School Nurse
- **SMR** = Special medical Room provided
- (-) = no information
Annex 3. Survey of country coordinators

The objective of this survey is to understand the experiences and opinions of country coordinators in the use of the Assessment and Improvement Tool for school health services in the WHO European Region. Feedback from the country coordinators will be used to refine the overall guidance, as well as to review the final version of the tool. Please note that the survey has two sections, one dedicated to structure and content and one dedicated to the assessment process itself. Please reply to both.

Thank you very much for your time.

1. Structure and Content

Think back to when you were going through the assessment tool. What was new to you? What did you think when you first read the questions? And how easy it was to understand the overall tool? Try to remember questions that you felt were unnecessary or questions that were missing.

1.1. Is the overall structure of the tool clear? Yes/No/Partially
1.1.1. If not, please indicate what could be improved.

1.2. Was the format of the tool (questionnaire) appropriate for assessing school health services? Yes/No/Partially
1.2.1. If not, what other format would you have preferred?

1.3. Was the language and the terminology used in the tool clear and easy to understand? Yes/No/Partially

1.4. Were there any questions that you did not understand? Yes/No
1.4.1. If yes, which question(s).

1.5. Were any of the Standards included in the tool completely new to you? Yes/No/Partially
1.5.1. If yes, please indicate which one(s)?

1.6. Do you have any suggestions or comments on how to improve the assessment tool, in terms of structure, contents or something else?

2. Implementation and assessment

Try to recall the entire process of participating in this assessment, from the first joint seminars with other countries, to the guidance provided in writing and the individual support you received during the assessment. Try to think of what was important to you in that process or what could have been better to help you or to improve the quality of your work.
2.1. Were the preparatory capacity-building seminars useful? Yes/No/Partially
   
   2.1.1. Please include any suggestions or comments (good or bad).

2.2. Did you receive enough guidance in verbal or written form on how to implement the tool? Yes/No/Partially
   
   2.2.1. If not, what could be improved?

2.3. Did you receive enough guidance in verbal or written form on how to carry out the discussions with the different stakeholders, including children and parents? Yes/No/Partially
   
   2.3.1. If not, what could be improved?

2.4. Was it easy to find the information you needed to complete the tool, through the desk review? Yes/No/Partially
   
   2.4.1. If not easy, what difficulties did you encounter?

2.5. Was it easy to prepare and implement the focus group discussions? Yes/No/Partially
   
   2.5.1. If it was not easy, what difficulties did you encounter?

2.6. Was it easy to integrate results from the focus group discussion, to complement the information gathered in the desk review? Yes/No/Partially
   
   2.6.1. If not easy, what difficulties did you encounter?

2.7. Do you have any suggestions or comments to improve the overall process of assessment?

Feel free to provide any other comments or reflections that you had during your experience, even if they were not included here.
Annex 4. Executive Summary: Armenia

The Assessment in the Republic of Armenia was conducted within between September and December 2020.

The aim of the study was to carry out a qualitative assessment of existing school health services, uncover any areas that need improvement, further develop the SHS, develop an appropriate health care policy and practice, and increase awareness in order to ensure high quality care and respect for the rights of the child.

A general methodology was developed for the group of nine European Region countries that participated in the SHS assessment in 2020. It is necessary to note that the process took place in conditions of the COVID-19 pandemic, and the methodology was thus adjusted to the restrictions and limitations. The desk review was carried out in order to identify the compliance of the SHS national regulatory framework to the European Framework for Quality Standards in school health services and Competences for School Health Professionals and children’s rights standards as enshrined in the Convention on the Rights of the Child (CRC), and is aimed at addressing the priority tasks of child health care.

All stages of the study were coordinated with the Ministry of Health of the Republic of Armenia. With due account of the situation with the COVID-19 pandemic, and later with the military actions in the period from 27 September to 10 November, four regions/marzes were selected for the assessment: Armavir, Yerevan, Syunik, and Shirak. In two districts, the assessment was conducted in both urban and rural schools; in one district, it was conducted in rural schools only; and in the capital city (Yerevan), it was carried out in public and high schools. The methodology was agreed with the WHO Regional Office for Europe and consisted of both qualitative and quantitative assessment methods. In total, the qualitative study was carried out in 10 schools, with teachers, deputy principals, school nurses, and parents being interviewed. A total of 86 adolescents aged 13–16 (54 girls and 32 boys) participated in focus group discussions and online surveys. Face-to-face discussions were conducted with all participants. Key stakeholders (doctors, leading experts in the field of child and adolescent health, representatives of non-governmental and international organizations) were interviewed both by phone and online. Adolescents participated in focus group discussions and online surveys using Google services. In accordance with ethical considerations, informed consent of the participants was obtained prior to conducting the assessment.

Results

The existing regulatory framework ensures the functioning of SHS. The decrees thoroughly describe the conditions and terms for health services in schools, their content, nurse actions, the principles of work, organizational standards, etc. SHS are available and accessible, all students are able to see a nurse and receive appropriate health care. In almost all districts, there were cases where a school nurse discovered a health problem and referred the pupil to the appropriate specialist to have the problem resolved. School staff provide medical screenings and are more or less involved in health lessons and solving hygienic and health issues in the school, referring students to other health professionals if necessary. An effective practice was observed in the city of Yerevan, where an outpatient clinic is staffed by a doctor in charge of the assigned schools who regularly supervises the work of schools and nurses (once per month), lectures for nurses are held twice a month, and meetings with teachers are held.
This practice is also carried out in health schools in areas where the nurses are supervised by the medical coordinator of a non-governmental organization.

However, the following problems were revealed:

- Inappropriate compliance with the decrees due to unawareness or lack of conditions.

- Lack of or insufficient infrastructure for children with physical disabilities; absence of protocols for nurses on the procedure for providing care to children with physical disabilities; insufficient coordination between all involved professionals.

- Lack of a system of accountability: in many places there is responsible person for school doctor/nurse supervision, meaning that their work is not monitored. Presence of SHS coordinator is described in the Decree of the Ministry of Health. However, no additional financing of this position is provided.

- Absence of indicators of quality, knowledge and skills assessment.

- Absence of a school health services and screening results database.

- Work overload in terms of reporting and filling out different logs and journals.

- Absence of medical rooms in some schools, and nurses in small schools.

- Absence of counselling skills among nurses.

- Absence of a system for informing adolescents and their parents about the care provided by SHS.

- Lack of confidentiality and information about confidentiality.

- Absence of established terms for replenishing medicine stocks and equipment for medical rooms.

- Insufficient collaboration with children, parents, and health professionals (or no collaboration at all).

- Lack of respect for school nurses, who are not seen as credible medical professionals.

- Lack of postgraduate education.

- Absence of a network of school nurses for experience exchange.

- Insufficient continuity between schools and outpatient clinics.

- Lack of access to up-to-date information for nurses; no access to internet in some places.

- Absence of informational materials in schools.

- Absence of specialized groups of physical education in schools.

- Not all schools are staffed with psychologists; insufficient psychological support in schools.
**Action points**

The following challenges should be addressed:

- **Leadership/government:**
  - Revision of the job descriptions and workload of nurses; creation of a position that is responsible for supervising and monitoring nurse activity, knowledge, skills and quality of work;
  - Establishment of school health services database;
  - Development of an integrated model of the work of nurses, school psychologist, responsible doctor in outpatient clinics in all regions of Armenia;
  - Revision of how medical rooms operate in schools; mapping of school health services; ensuring the availability of all necessary medicines in medical rooms and monitoring the replenishment of medicines in all regions and rural areas;
  - Regulations for medicines, the replenishment of medicines and medical room equipment; updating medical room equipment;
  - Simplification of the data management system;
  - Ensuring appropriate conditions for rendering care to children with physical disabilities;
  - Supportive legislation;
  - Use of resources; proper use of staff working hours;
  - Up-to-date and appropriate guidelines and protocols;
  - Capacity-building and management;
  - Monitoring and assessment, accountability system;

- **Financing:**
  - Efficient spending of budget funds;
  - Financial resources necessary for ensuring stable work;
  - Determining pay for additional workload;
  - Financing the nurse position in schools regardless the number of students;

- **Health professionals:**
  - Competent and specially trained;
  - Staffing (favourable structure, lack of staff);
  - Increasing motivation among nurses and their credibility/respect;
◊ Supervision of staff work, prompt and appropriate feedback;
◊ Opportunity for frequent unified postgraduate education;
◊ Undergraduate training in counselling skills and adolescent development;
◊ Establishment of a school nurse network with experience exchange;
◊ Appointment of responsible doctors and connection with doctors in out-patient clinics and ambulatories;
◊ Improving continuity between schools and outpatient clinics;
◊ Collaboration with a school psychologist;
◊ Provision of information about the services offered to adolescents and their parents;
◊ Collaboration with teachers, parents, health professionals, social and other services and community level;
◊ Compliance with HLS policy in schools;
◊ Active involvement of nurses in HLS lessons in schools;

• Equipment/technologies:
  ◊ Appropriate equipment and technologies;
  ◊ Physical environment in schools, access to drinking water, sanitation;

• Information:
  ◊ Data storage and management;
  ◊ Stable access to the internet, access to up-to-date information for nurses;
  ◊ Simple and non-time consuming accountability systems;
  ◊ Communication strategy – involving adolescents in the development of health promotion materials;
  ◊ Making informational materials available in schools;
  ◊ Providing information about online resources for adolescents;

• Services:
  ◊ Patient satisfaction;
  ◊ Promptly rendered services;
  ◊ Attending to student needs, including those of children with physical disabilities and children with chronic disorders;
◊ Prevention of non-communicable diseases;
◊ Protection of children’s rights;
◊ Eliminating discrimination;
◊ Confidentiality;
◊ Psychological support;
◊ Communication that is convenient for patients;
◊ Availability of specialized groups of physical education in schools;
◊ First aid and emergency care training for all students and teachers.
Annex 5. Executive Summary: Azerbaijan

**Aim of the study:** The Assessment tool is designed to assist those responsible for school health services at the national and regional level to assess compliance of SHS with the European Quality Standards in school health services and define the scope for improvement of SHS by informing the development or revision of policies, guidelines and standards. The main aim is to develop recommendations based on the assessment results. The assessment facilitates the further development of SHS and is aimed at revealing areas that need improvement, as well as at raising awareness.

In order to ensure a high quality of services and the fulfilment of children’s rights, the development of this assessment tool was based on a variety of existing WHO frameworks, strategies, reports and manuals adapted specifically for SHS.

**Methodology:** desk review, interviews with key informants, focus group discussions (both online and face-to-face).

During the desk review, the documents were thoroughly reviewed in order to collect all relevant available information about the SHS (i.e. legislation, policies, services, guidelines, standards, ongoing and/or planned reforms, funding and staffing issues, surveys, and monitoring reports). Data collection was carried out by the CPHR experts.

Interview with key informants: The purpose of the in-depth interviews with the key stakeholders was to collect data that was missing in the desk review, or to complete and validate information.

The following key informants were interviewed:

- Nigyar Bagirly – Adviser to the Minister of Education on Health issues
- Rustam Agaev – Adviser to the Minister of Education on Health issues
- Teimur Musaev – Head of the Department of Health Care Organization of the Ministry of Health
- Nelli Veysova – Head of the Health Department of Baku City
- Esmira Gadzhieva – Inspector of the Health Department of Baku City on school health services
- Ainur Zeinalova – Adviser of the Department of Health Care Organization of the Ministry of Health
- Tamilla Gadzhieva – Head of the Department of Paediatrics, Polyclinic No. 15
- Ediliya Guseinova – Chief Paediatric Physician, Polyclinic No. 5

Focus group discussions helped to collect and summarize the opinions of specific stakeholder groups (school nurses, doctors, psychologists, teachers, school administration, students and parents).

The assessment of national school health services was launched after the relevant letter was received from the Director of the National Medical Research Center for Children’s
Health of the Ministry of Health of the Russian Federation, Andrey Fisenko. The letter was addressed to Minister of Health of the Republic of Azerbaijan Oktay Shiraliyev and proposed carrying out an assessment of the country's health school services in order to improve such services in the WHO European Region as a whole. In response, Sabina Babazade, coordinator for the Health Promoting Schools initiative, was appointed project coordinator for the assessment.

Preliminary work began in November 2020. Official letters were sent to the relevant departments and agreements were received. Persons in charge of assisting in the organizational work were assigned. The Assessment of National school health services was carried out between 1 December 2020 and 1 May 2021.

The Ministry of Education selected 25 schools to take part in the assessment. The sampling was based on the following considerations: economic and geographic factors; schools with large and small numbers of pupils; and city/district/rural area.

Azerbaijan is divided into economic regions based on geographic location, territorial and economic unity, the uniqueness of natural and economic conditions and historical industrial specialization. Two schools from each of the nine economic regions were selected. Schools with large and small numbers of pupils, as well as schools from big cities, districts and rural areas were taken into account during the sampling.

**Main results**

- The national normative framework and state programmes involving the ministries of health and education and based on children’s rights are in place.

- All school health services in the country respect the characteristics and quality aspects of child- and adolescent-friendly health services. The services are provided based on the principles of equity, accessibility, acceptability (confidentiality), participation, efficacy and safety for all schoolchildren, regardless of their status. Good practices in the country include assisting SHS in its work and meeting all the principles of this standard. These are: “Schoolchild’s friend,” “Healthy education – Healthy nation,” “Minor Academy” – as a one-school experience. All schoolchildren, including migrants and refugees, have free access to health care.

- All educational materials are developed at the national level.

- Collaboration among SHS staff and teachers is established. SHS staff participate in the development of curriculums for students with health conditions. Parents of schoolchildren are informed about the health issues and health services.

- Health professionals have clearly defined and approved job descriptions. Health professionals provide counselling at schools, but not preventive medical check-ups. Health professionals undergo professional development and certification training.

- Schoolchildren can approach SHS staff with health issues at any convenient time without preliminary appointment.

- Electronic case histories are in place in the country, primary health care staff have access to this database. The database system is being updated and improved during the transition to the compulsory health insurance (CHI) system.
• There is no unified strategy, federal programme, or any other policy specifying the content and conditions for the provision of SHS that can be referred to in order to improve such services. Due to reforms in the country and the transition to the CHI system, there are staff cuts and temporary closing of medical rooms in some regions. As the reforms are in progress at present moment, it would be appropriate to highlight SHS issues in the newly developed documents.

• The quality of school health services is not assessed in the country. There are no surveys for students to provide feedback or give their opinions regarding the care provided.

• Medical rooms do not always comply with the adopted norms and standards. Some schools do not have medical rooms at all. Schools with medical rooms that have been closed temporarily due to the transition to the Compulsory Health Insurance (CHI) system also participated in the assessment.

• The school health system is plagued by understaffing and an inadequate number of health professionals and psychologists.

• There are no motivational or reward mechanisms for SHS staff.

• Exiting standards are not updated with the changes that reflect the needs, knowledge, resources and priorities of students.

• Material and technical support is not adequate.

**Main Recommendations/Next steps**

• It is necessary to develop and approve a unified policy, state programme or other unified strategic document that can be referred to during the improvement of SHS.

• The quality of health services provided in schools is not assessed in the country. Surveys aimed at getting feedback from students about their health and what they think of the health services provided are not carried out. Based on the assessment results, we approached the Ministry of Health with the proposal to carry out surveys and situational assessment. In reply to this proposal, the Ministry of Health tasked the Public Health Center with carrying out surveys among schoolchildren.

• The transition to the Compulsory Health Insurance (CHI) system means that norms and standards for SHS medical rooms are to be updated. This will improve the quality of services provided to schoolchildren by health professionals.

• Provide school health professionals with the access to the electronic health case history database.

• Improve training courses for school nurses, and establish a system of continuous participation in such courses.

• Proposals on staffing schools with health professionals and psychologist will be submitted to all relevant ministries.
• Proposals on the development of a motivational and reward system for SHS staff will be made.

• The assessment results will be submitted to all stakeholders and discussed at a round table meeting.

• Improvement of the material and technical resources.
Annex 6. Executive Summary: Belarus

The Assessment of the school health services system in the Republic of Belarus for the purposes of the following situational analysis and the identification of the main challenges was carried out between November 2020 and April 2021 and consisted of three steps (described in the Methodology section).

The total number of respondents was 2222, including: 102 health professionals; 21 teachers, school psychologists and school administration staff; 498 legal representatives of students; and 1601 students aged between 6 and 18. Students from the urban and rural areas participated in the assessment.

Main results

According to the analysis, the current SHS system in the Republic of Belarus in general complies with the European Framework for Quality Standards in school health services and Competences for School Health Professionals (WHO).

The Assessment revealed low motivation among students and their legal representatives to collaborate with school health professionals, as well as low commitment to leading healthy lifestyle. It is extremely important to promote fruitful collaboration between students, their legal representatives, health professionals, teachers and administrative staff. One way to do this may be to develop a feedback system, such as surveys on official websites of educational facilities with an analysis of responses and proposals.

Electronic data management processes are expected to be implemented on a wide scale, which will make it possible to improve the data management and storage system and introduce reporting systems that are quick and easy to use. This requires stable internet access. It is very important to choose compatible automated data management systems.

The following current national programmes, policies and national action plan are aimed at resolving these and other issues:


- State Scientific Technical Programme “Digital Technologies and Robotic Systems” for 2021–2025 (the main goal is to develop national digital technologies and unmanned aerial robotic systems for defense, economics, health and social welfare);

- State Scientific Technical Programme “Scientific and Technical Provision of High Quality Health Services” for 2021–2025 (the main goal is to improve the quality and duration of people’s socially active lives by improving the quality and availability of health services, developing and implementing modern effective methods and means of disease prevention, diagnostics and treatment, and prosthetics and rehabilitation);

- Development concept of the digital health care in the Republic of Belarus for the period until 2022;

Annex 7. Executive Summary: Kazakhstan

Timeline

The Assessment of the school health services started on 8 September 2020 with a review of the existing regulatory framework and ended on 5 February 2021 with the preparation of the assessment technical report.

Methodology used in the collection of data

The following activities were performed as part of the assessment: an analytical review of the regulatory framework for the implementation of school health services in the Republic of Kazakhstan; a retrospective analysis of the data reported by the health authorities and agencies; identification of the key informants and assessment participants, with due account for geographical conditions and representativeness in a number of regions (Nur-Sultan, Akmola Region, Kyzylorda Region, East Kazakhstan Region, and Atyrau Region); interviewing key stakeholders using the Questionnaire for the Assessment of school health services; and focus group discussions based on the Guidance for Gathering Information through different Groups of Stakeholders.

The list of questions for interviewing the key informants, conducting focus group discussions with key stakeholders and carrying out the online survey were adapted in accordance with the current settings and translated into the Kazakh language.

Focus group discussions were held to gather and summarize the views of the representatives of the certain groups of stakeholders (school children of different age groups, school health professionals, teachers, school management, parents), focusing on specific issues and topics. Due to restrictions caused by the COVID-19 pandemic, face-to-face meetings were limited and the majority of interviews and discussions were held on Zoom, by telephone or with Google Forms.

Main results

During the assessment process, a dialogue was established between key SHS stakeholders that identified the strengths and weaknesses of the existing model and developed recommendations on SHS capacity-building, including systematic monitoring and assessment.

The review and analysis of the national SHS legislative and regulatory framework to ensure its compliance with the European Framework for Quality Standards in school health services and Competences for School Health Professionals and children’s rights standards, as enshrined in the Convention on the Rights of the Child, demonstrated the existence of a legislative framework regulating SHS activities that meets the relevant needs of the system in general.

The interviews with the key informants and focus group discussions with the key stakeholders demonstrated that additional regulatory standards need to be introduced in order to improve the processes that ensure the effective implementation of the following aims and objectives:
• ensuring confidentiality during preventive medical check-ups of students;

• ensuring equal access to health services for all schoolchildren and continuity of PHC services through a revision of the regulations on registering children and school students with health facilities based on territorial and occupational principles;

• solving issues of staffing, workload standards and motivation of staff;

• standardizing school health services;

• ensuring that children and parents are involved in the development of standards and regulations regarding the SHS activities;

• ensuring full coverage of the SHS with medical information systems.

Main recommendations and next steps

The SHS Assessment resulted in recommendations for key stakeholders responsible for policy and strategy development in the field of health, as well as for persons responsible for the implementation of such policies at the regional and local levels to support the further development of national standards of high-quality services meeting the health-related needs of children and adolescents.

Political commitment to child and adolescent health, which will contribute to the effective intersectoral collaboration of all key authorities and agencies involved in SHS activities, is needed to coordinate the work to improve school health services. At the level of the Government of the Republic of Kazakhstan, special attention should be paid to establishing conditions for providing internet access across the country, including in remote rural regions; full-scale automation and digitalization of school health services; and regular monitoring and assessment of key activities and interventions.

At the level of the Ministry of Health of the Republic of Kazakhstan, priorities of school health services within the PHC system should be strengthened; capacity-building of the existing school health services model should be carried out, including improving the quality of services to meet the health needs of children and adolescents as a primary result. All this has a potential beneficial effect on academic performance, attendance and concentration in class, and also contributes to the formation of a healthy school environment.

Furthermore, the authorities should consider establishing a specialized department within the PHC system for providing health care to children in educational facilities, with the approved multidisciplinary staff structure, including a head of the department, paediatrician/general practitioner (at a ratio of 1 doctor per 1500–2000 students), senior nurse, manager-statistician, nutritionist, physical education specialist, physiotherapist, and nursing staff (at ratio of 1 nurse per 500 students).

In order to standardize and improve the quality of school health services, uniform standards for the quality of school health services and competencies of school health professionals should be introduced, with qualification requirements, job responsibilities, work regimen and algorithms for the provision of health care clearly stated.
In order to improve SHS staff capacity:

- SHS staff should be trained in additional skills and competencies for working with adolescents and providing them with the health services they need, including professional counselling in private hygiene, sexual, mental and physical health according to age;

- Stimulating and motivational mechanisms should be established for SHS staff in order to improve staffing, including competitive wages;

- A standard of the workload distribution for SHS paramedic staff according to the working hours of educational facilities and the current labour legislation of the Republic of Kazakhstan should be introduced (shifts of 5–6 hours per day can be considered).

To strengthen the monitoring and reporting system, the full integration of the HIS to the operational SHS processes should be ensured across the country, taking the opinions of the SHS professionals into account on the relevance, adaptability and usability of the information support systems.

In order to improve SHS services it is necessary to:

- revise the measures for ensuring continuity of SHS health care according to the territorial and occupational principle;

- provide conditions for the regular assessment of SHS screenings in terms of their compliance with the evidence base; non-evidence-based screenings should be revised;

- pay more attention to communication of SHS staff with children and parents and informing them about the list of services offered;

- provide conditions for the active involvement of children and adolescents in decision-making according to their evolving capabilities; engage them in the development of programmes and assessment and delivery of SHS services;

- provide standards that will ensure the complete confidentiality of medical examinations and informing students in SHS;

- implement strategies on informing children, parents and school staff on the work of SHS at the local level, engaging local communities and using different means and channels of communication.

To achieve optimal results in this area, a dialogue with the education, labour and social protection authorities is needed, and a National Plan for improving school medicine in Kazakhstan needs to be developed in order to gradually strengthen school health services to meet the needs of children and adolescents.
Annex 8. Executive Summary: Kyrgyzstan

A qualitative study of school health services was conducted in the Kyrgyz Republic between December 2020 and January 2021 that included a sample survey of school children aged 8 to 18, school administration, teachers, school health workers and parents. The study aimed to collect data and help form a better understanding of the effectiveness, quality, processes and functions of existing school health systems as part of the “Study to assess national school health systems (SHS) in the countries of the European Region and improve them.”

The study was conducted using special questionnaires for each category of stakeholder groups and additional guidance on conducting discussions in five focus groups: children in grades 1–5 and 6–11, parents, school administration and teachers, school health workers.

The main results of the study showed that SHS are not developed in the schools of the Kyrgyz Republic. School children receive a minimal package of services provided by medical workers who work part-time in cities and district schools. There are no medical rooms in rural schools and children are forced to seek health care in the local health centers or Family Practices. Medical personnel responsible for SHS are not motivated, receive little or no training and lack evidence-based guidelines, manuals, and supportive legislation to provide quality medical care.

In the Kyrgyz Republic, it is necessary to improve the normative and legislative basis for implementing school health care system that is built on evidence-based medicine, international standards, and best world practices. The following steps are recommended:

- Development and adoption of a Law on the protection of the health of children and adolescents in the Kyrgyz Republic;
- Development of a comprehensive multidisciplinary and intersectoral programme for protecting the health of children and adolescents in the Kyrgyz Republic;
- Development of an intersectoral order by the Ministry of Health and the Ministry of Education and Science of the Kyrgyz Republic to improve the quality of services provided to children in educational institutions;
- Strengthen cooperation between the Ministry of Education and Science and the Ministry of Health and Social Development to improve SHS.
Annex 9. Executive Summary: Russian Federation

The school health services Assessment within the framework of improvement of the school health services in the WHO European Region was carried out in the Russian Federation between October 2020 and January 2021.

The assessment process involved creating a working team, gathering and studying the normative and regulatory corpus, adapting the necessary tools (questionnaires and surveys) with the assistance of teachers, child psychologists and health professionals (adapting the terminology in the questionnaires and surveys, explaining certain questions to parents and teachers), and obtaining detailed information on each of the Standards from different groups of stakeholders and key informants.

Data was collected from different groups of stakeholders in order to identify the gaps between the regulatory framework and the existing practice of the school health services; assess the knowledge, skills, attitudes and collaborative mechanisms of the staff of educational facilities, teachers, health professionals, health services leadership, and students; identify the information that children and adolescents receive; understand which categories of children do not use health services; and gather any other relevant information.

Focus group discussions were held both online (via Zoom and Skype and in the form of electronic questionnaires) and face-to-face:

- The researchers collected data from adult informants during focus group discussions in a mixed format, mainly face-to-face. Structured interviews, electronic questionnaires and subsequent focus group discussions were used for parents, school administration and SHS staff. Discussions were held both online and face-to-face.

- Semi-structured interviews and focus group discussions in mixed formats were held for children aged 6–9 years and adolescents aged 10–19.

- Online semi-structured interviews (the answers were not limited by time) were held for groups of 1–5 adolescents (aged 15 years and older); the means of communication were selected by the adolescents themselves (Zoom, WhatsApp, Skype).

Adolescents were selected to the interview groups by gender and age. Interviews with the primary school children were held with the permission and in presence of their parents/caregivers. All participants in the assessment were informed about its goals and gave their consent to participate.

The assessment helped highlight and describe the strengths and weaknesses of the school health care system. An analysis of the normative and legislative framework of the school health services showed that protocols, legislation, and the package of school health services in general comply with the European Framework for Quality Standards in school health services and Competences for School Health Professionals. Examinations and interviews with students are held in confidential conditions (individually), in well-equipped and clean rooms or health units within the educational facility. Educational facilities have the necessary premises, equipment, and data management systems that ensure the protection of students’ health and allow the data obtained to be monitored.
The main problem arises during practical implementation at local levels. Insufficient financing of SHS means that staffing is difficult, and salaries and motivation among SHS are low. School health professionals do not provide the required level of activities aimed at encouraging a healthy lifestyle and developing a culture of family health, including education for parents/caregivers. Children, parents and teachers do not participate enough in the development and implementation of health promoting programmes.

The relevant authorities (the Ministry of Health and the Ministry of Education of the Russian Federation) are aware of the existent problems in the SHS system, and priority national projects, such as the “School Medicine” pilot project launched in five regions of the country in 2016 at the initiative of the Ministry of Health of the Russian Federation (selection of the best practices with the further distribution across the country), have been introduced to improve SHS.

Main recommendations

- Include pricing rates and payments for preventive and educational work performed by school health professionals in the MMI system.

- Develop a system for informing parents and children about the health services offered in the school medical rooms.

- Develop unified requirements for medicines and dressing materials in first-aid kits for children in school medical rooms.

- Develop and systematize an electronic database of modern health promotion educational materials at the federal level and make educational and methodical materials, including in printed versions, available for every school.

- Develop federal health promotion activities for children in collaboration with children themselves, their parents and school health professionals.

- Ensure active collaboration in the protection of schoolchildren’s health between school health professionals and paediatric clinics.

- Ensure active collaboration between school health professionals and psychiatrists, narcologists, youth counselors, psychologists, law enforcement officers, guardianship services and other groups in the event that deviant and/or asocial behaviour (alcoholism, drug addiction and substance abuse, smoking, vagrancy, involvement in criminal activities, etc.) is spotted in minors.

- Improve the SHS staff training system, increase their motivation and salaries.

- Ensure protected access to information on schoolchildren’s health for all SHS staff.

Next steps

- To develop a national action plan aimed at resolving the weaknesses revealed during the current assessment.

- To develop recommendations on SHS improvement at regional levels.

- To distribute information about the measures and recommendations on the improvement of SHS in Russia among all groups of stakeholders.
Annex 10. Executive Summary: Tajikistan

The present report contains the main results of the assessment of school health services in the public education facilities of the country. In general, school health services do not function in schools as they should. However, there are certain trends that give cause for optimism in the improvement of the school health services, provided that clear mechanisms for implementing new strategies are developed and current policies aimed at promoting the health and wellbeing of schoolchildren are supported. The present report provides an overview of the current situation in schools, and its results will be used to launch a comprehensive programme to improve school health services in public secondary schools in the Republic of Tajikistan. The assessment was carried out in Dushanbe city schools, as well as in schools in the districts and settlements of four regions of the country. Despite the fact that COVID-19-related issues were not covered by this assessment, the influence of the pandemic on the health services should be considered during the decision-making process and the discussion of the assessment results.

Timeline

The assessment started in December 2020 and continued until the end of January 2021. The research team then prepared and submitted a national report that was discussed and updated based on the questions and comments of the WHO and SHE consultants.

Workshops were held on the following issues:

- Capacity-building workshops on the Assessment tool and its implementation (28 August and 4 September 2020).
- Guidance workshops on how to carry out focus group discussions with stakeholders (25 September and 6 November 2020).
- Workshops for the exchange of information between country representatives and international experts on the results of different phases and planning of subsequent phases (25 September and 6 November 2020).

The steps of the assessment were as follows:

- Desk review of the SHS national legal and regulatory frameworks, including compliance with the European Quality Standards in school health services, as well as child rights standards, in particular those enshrined in the CRC, and of the extent to which SHS sufficiently target and address priorities for child health (October–December 2020);
- Interviews with key informants (November–December, 2020);
- Focus group discussions with stakeholders (children, adolescents, school nurses, teachers, parents and school administration) (November–December, 2020);
- Online country consultation between individual country representatives and international experts (November–December, 2020).
- Methodology used in the collection of data.

A common methodology was offered for the Republic of Tajikistan, as well as
the other countries of the European Region. The methodology was agreed upon during the height of the COVID-19 pandemic, meaning that it was tailored in accordance with the restrictions in place at the time.

The team participated in different online workshops on issues of school health and children rights. These events were attended by representatives of other countries, WHO employees and international experts.

Four regions and 10 districts were selected for the assessment. In total, four specialists and over 400 key informants, including school principals, school health professionals, teachers and students from different grades, as well as other non-teaching staff, participated in the interviews. Face-to-face discussions were carried out in nine schools and online discussions were carried out in six schools. Each focus group included between 18 and 27 teachers and between 28 and 33 students. Meetings with teachers and students were held separately; however, in one case, class teachers also participated in the focus group discussion with students. Both urban and rural schools, as well as schools with migrant and refugee children (mostly from Afghanistan), national minorities (Lyuli – the local Roma population) and schools located in remote mountain regions were assessed.

**Main results**

Approximately 10% of schools are staffed with health professionals, with 15 national schools for talented children and 63 boarding schools having full-time health professionals. However, the majority of private schools are staffed by both nurses and doctors. Not all the private schools comply with the SHS requirements. These are mostly schools located in the capital and major cities. All schools are funded on a per-pupil per capita basis. Existing funding is insufficient and schools cannot independently manage budget funds without the approval of the Ministry of Finance. The allocated funds are not used rationally; the main part of the budget is allocated to pay salaries of the school staff (more than 90%) and the maintenance of the school building and the surrounding area, etc. Improvements in the financing of school nutrition are expected soon, including changes to the school budget that will include a separate section on school nutrition starting in 2022.

We should also note that some of the older students were found to have mental health and social problems. Children in some schools mentioned that they did not have access to a school psychologist. They also expressed their discontent with the poor attitude of teachers towards them and the lack of communication between teachers and students.

Unfortunately, nutrition for children in public schools leaves much to be desired. All the school canteens visited by the assessment team sold fast food and carbonated beverages instead of healthy alternatives. In addition, the water, sanitation and hygiene conditions in many schools do not comply with the norms. In rural schools, toilets were located far from the school building. This is not convenient, especially in winter and especially for girls.

**Main recommendations and next steps**

First of all, the assessment showed the necessity to develop an SHS improvement policy by forming an intersectoral/interagency group. Based on strategy aims and objectives, midterm programmes need to be developed for the implementation of the strategy. Discussions of the SHS assessment results among various interagency working groups
should focus on determining the main aims and objectives of the SHS policy. The policy should take the input (and opinions) of children, adolescents, parents and nurses given during the assessment into account. If possible, these groups of stakeholders should be engaged in the development of the policy. The development of a clear monitoring and assessment plan to supervise the progress, gaps and achievements, establish intersectoral collaboration, especially between the health and education sectors, and secure such collaboration in joint protocols/memorandum, is also a key component of policy development. Partnerships should be developed with the local authorities and schoolchildren should be actively engaged in all school health processes.

It is necessary to make sure that all SHS activities are welcomed and supported by parents, PHC, teachers and students. Greater attention should always be paid to the most vulnerable children – those from low-income families living in the most remote highland regions.

Our understand of what needs to be done should not be based exclusively on academic knowledge and evidence. A monitoring and assessment system for all the activities provided needs to be developed. Most importantly, teachers must not be overloaded with health-related tasks, as their major task is to teach children. It is also necessary to develop training manuals and training modules and integrate them into the training programmes/curriculums of the secondary and higher education facilities (colleges, universities, etc.).
Annex 11. Executive Summary: Uzbekistan

The implementation of the project in the Republic of Uzbekistan took place between December 2020 and September 2021. The project is a part of an ongoing international process that aims to improve the quality of health care services for children and adolescents, as well as to ensure compliance with children’s rights standards, as enshrined in the Convention on the Rights of the Child.

The activities regarding the establishment of Health Promoting Schools were included in the State Programme on the Further Development of Health Care adopted by the President of the Republic of Uzbekistan.

The assessment was conducted in accordance with the common methodology developed for the group of nine European Region countries. It should be noted that the assessment was carried out during the COVID-19 pandemic, so the methodology was adapted in accordance with the relevant restrictions.

The steps of the assessment were as follows:

1. Desk review of the legal and regulatory framework;
2. Adaptation and translation of the Assessment tool into the national language and its distribution;
3. Selection of schools for participation in the assessment;
4. Focus group discussions with administration/principals of the selected schools; health professionals (doctors and nurses), representatives of the education sector (teachers); children and adolescents; parents and caregivers;
5. Analysis of the data, completing the summary tables, specifying strengths, challenges and gaps revealed during the assessment.

The assessment revealed that different regions of the Republic of Uzbekistan face the exact same challenges when it comes to the quality of health services provided to students in educational facilities. These include lack of staff and low remuneration of their work; inadequate training and low motivation of SHS staff; inadequate financing and equipping of school medical rooms; poor continuity in work and data exchange between education and health facilities; low informatization of school health services; absence of indicators for monitoring the services provided and improving their quality; and especially, insufficient participation of families/caregivers, as well as teachers and/or other local community members in the child health promotion programmes and activities (development and implementation).

The similarity of the challenges in different regions of the country indicates the need for a nationwide policy to overcome them, which should include health staff training, the identification of the main types of health services provided in schools, the development of a material and technical base for school medical units, and the improvement of expert and analytical work in health and educational facilities.
The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Türkiye
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00   Fax: +45 45 33 70 01
Email: euwhocontact@who.int
Website: www.who.int/europe