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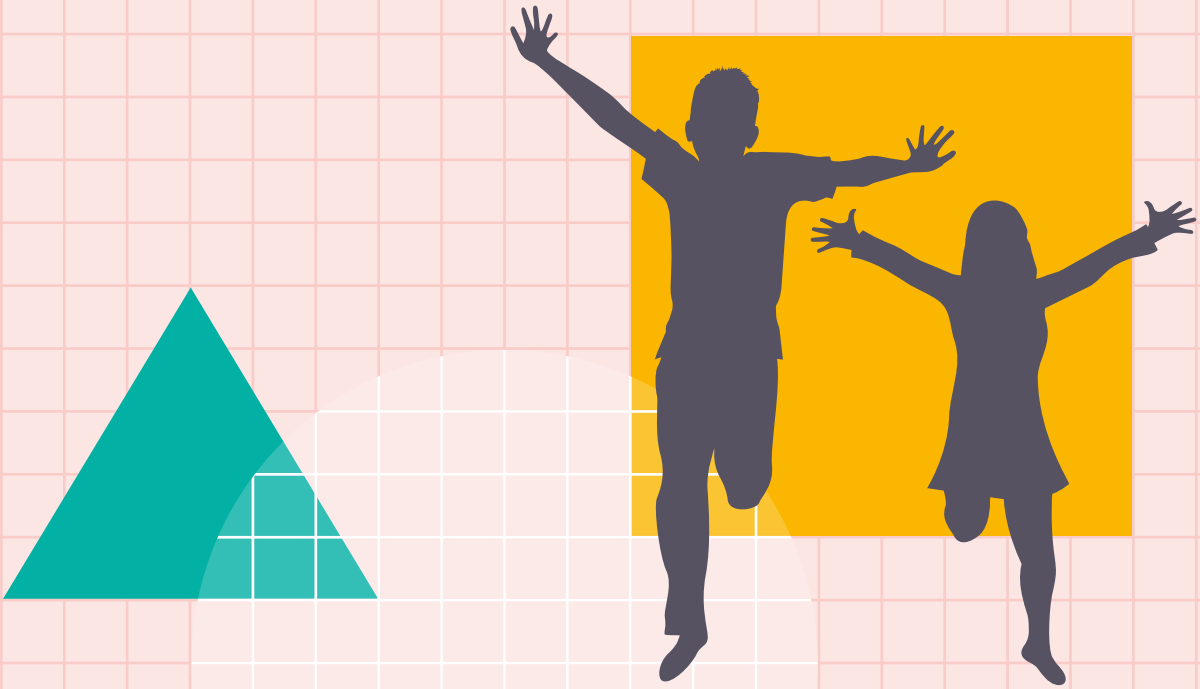

Making every school a health-promoting school

Country case studies

Education 2030

World Health Organization

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Making every school a health-promoting school

Country case studies

Education 2030

Making every school a health-promoting school: country case studies

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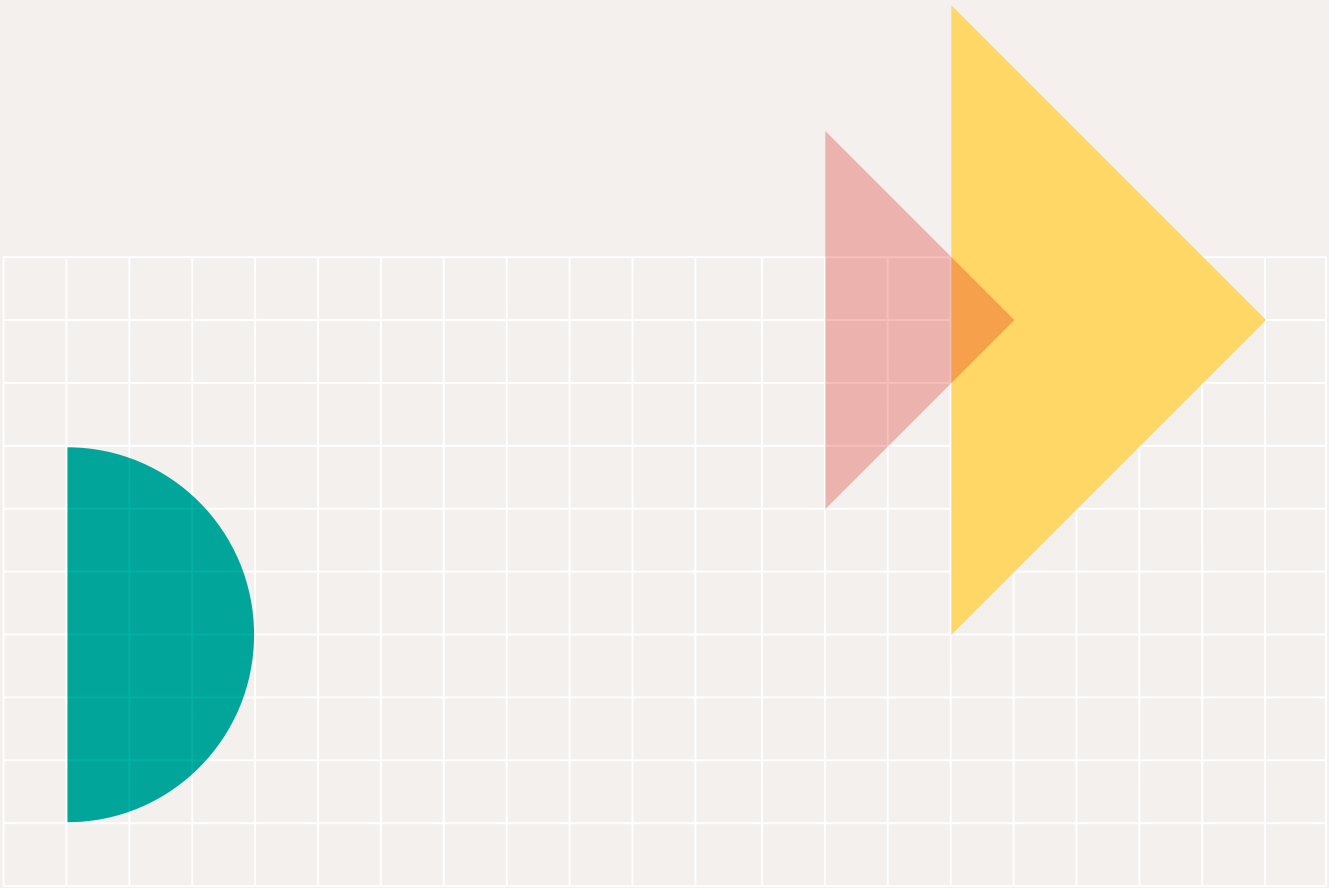


Foreword

Around the world, schools play a vital role in the well-being of students, families and their broader communities.

The closure of many schools during the COVID-19 pandemic has caused severe disruptions to education, caused an estimated 365 million primary school students to go without school meals and significantly increased rates of stress, anxiety and other mental health issues. Past experience also tells us that in some parts of the world, when schools close for more than a few weeks, there are increases in early and forced marriage, early pregnancy, child labour and domestic violence.

The right to education and the right to health are core human rights and essential to social and economic development. Now more than ever, it is important to make all schools places that promote, protect and nurture health and that contribute to well-being, life skills, cognitive and socioemotional skills and healthy lifestyles in a safe learning environment. Such schools are more resilient and better able to ensure continuity in education and services, beyond the delivery of literacy and numeracy.

The idea of health-promoting schools was first articulated by WHO, UNESCO and UNICEF in 1995. Yet few countries have implemented it at scale, and even fewer have made the institutional changes necessary to make health promotion an integrated and sustainable part of the education system. In 2015, experts in health-promoting schools identified the lack of systematic support, limited resources and a common understanding and approach as major challenges.

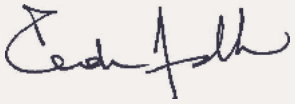
Yet no education system can be effective unless it promotes the health and well-being of its students, staff and community.

Every education system should have institutionalized policies, mechanisms and resources to promote health and well-being in all aspects of school life, including teaching, curriculum and school governance based on participatory processes that are inclusive of the broader community. This requires re-orienting education systems towards a systematic approach to health-promoting schools and allocation of resources so that each level of governance has the infrastructure and the means to implement policies and programmes for better education, health and well-being.

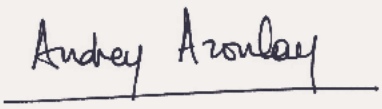
The Global Standards for Health-promoting Schools provide a resource for education systems to use to foster health and well-being through stronger governance. Building on a large body of evidence, eight global standards are proposed, while the accompanying Implementation Guidance details 13 implementation areas, associated strategies and a process that will enable country-specific adaptation. In addition, several case studies illustrate how health promotion in schools is being implemented in low- and middle-income countries.

If implemented, these global standards could improve the health and well-being of 1.9 billion school-aged children, adolescents and staff worldwide, delivering a triple dividend for students today, the adults of tomorrow and the generation of children to come.

Join our effort and let's "Make Every School a Health-promoting School".



Dr Tedros Ghebreyesus
Director-General
World Health Organization



Audrey Azoulay
Director-General
UNESCO

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Abbreviations and acronyms

COVID-19	coronavirus disease 2019
HPS	health-promoting schools
HSS	healthy school strategy
LMIC	low- and middle-income countries
OECD	Organization for Economic Cooperation and Development
UKS	*Usaha kesehatan kekolah* (school health programme in Indonesia)
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

Glossary

Curriculum: "A collection of activities implemented to design, coordinate and plan an education or training schedule. This includes the articulation of learning objectives, content, methods, assessment, material and training for teachers and trainers" *(1)* that enables students "to develop skills, knowledge and an understanding of their own health and well-being and that of their community" *(2)*. It includes planning, development and students' educational experience beyond the classroom.

Governance: The rules, mechanisms, relationships and processes by which HPS activities and roles are led, managed, monitored and held to account for use of allocated resources and achievement of specified objectives.

Health: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" *(3)*.

Health promotion: "Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions" *(4)*. Its scope and activities are ideally comprehensive and multifaceted. Often framed in the context of prevention strategies for a group, community or population, it is also embodied in individual approaches, such as treatment and continuous care.

Health-promoting school: A school that consistently strengthens its capacity as a safe, healthy setting for teaching, learning and working *(5)*. The global standards and indicators and the implementation guidance are applicable to any whole-school approach to health, even if the term "HPS" is not used (e.g. comprehensive school health, school for health, healthy learning environment, *école en santé, escuela para la salud*).

Implementation: Conduct of a specified set of activities to establish or put in place a programme *(6)* or initiative. The activities include identification of an issue, determination of a desired outcome, planning, use of monitoring and feedback, collection and use of data and collaboration of internal and external stakeholders *(7)*. Particularly in schools, implementation is considered to represent complex interactions among the characteristics of the education system, implementers and the organizational context *(8)*.

Indicator: A variable used to monitor or evaluate specific, measurable progress towards completion of an activity, output, outcome, goal or objective *(9, 10)*.

Intersectoral collaboration: A working relation between two or more sectors to achieve health and education outcomes in an effective, efficient, sustainable manner *(11)*.

Local community: Both the local (geographical) community of people living or working near a school and various organizations external to the school that engage with students or staff at the school. May include local government authorities, nongovernmental organizations, faith-based organizations, private enterprises, community health services and community groups such as youth groups and providers of organized sports, arts and other culture.

Parents: Comprises parents, caregivers and legal guardians of students.

Resources: Any financial, information, human or physical resources.

School: An institution designed to provide compulsory education to students at both primary (elementary) and secondary (junior and senior high school) levels.

School community: All school staff, including teachers, school governors (e.g. school board members) and other staff (e.g. administrative staff, cleaners, health professionals) and volunteers who work in the school, students and parents, caregivers, legal guardians and the wider family unit.

School health service: Health services provided to students enrolled in primary or secondary education by health care and/or allied professionals, which may be provided on site (school-based health services) or in the community (school-linked health services). The services should be mandated by a formal arrangement between the educational institution and the health-care providers' organization *(12)*. The term "comprehensive" is consistent with the WHO guideline on school health services *(13)*.

Stakeholder: A person, group or organization with an interest in or that may be affected by the implementation of HPS (or similar). They include individuals within the school community such as students, parents, teachers, administrative staff, HPS coordinators and principals. Stakeholders outside the school may include local health service providers, business owners, United Nations agency staff, nongovernmental organizations and their representatives and district, provincial and national ministerial staff.

Sustainability: The degree to which an initiative is maintained over time or institutionalized in a given setting *(14)*

Well-being: A physical, emotional, mental and social state "in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community" *(15)*.

Whole-school approach: "An approach which goes beyond the learning and teaching in the classroom to pervade all aspects of the life of a school" *(2)*. Includes teaching content and methods, school governance and cooperation with partners and the broader community as well as campus and facility management. It is a cohesive, collective, collaborative approach by a school community to improve student learning, behaviour and well-being and the conditions that support them *(16)*.

Whole-of-government: Joint activities coordinated and performed by multiple sectors and levels of government towards a common goal or solution.

Summary

Every school should be a health-promoting school.

No education system is effective unless it promotes the health and well-being of its students, staff and community. These strong links have never been more visible and compelling than in the context of the COVID-19 pandemic.

A health-promoting school (HPS) approach was introduced over 25 years ago and has been promoted globally since; however, the aspiration of a fully embedded, sustainable HPS system has not yet been achieved, and very few countries have implemented and sustained the approach at scale.

How can we make every school a health-promoting school, and how can we implement, sustain and scale up the approach at country level, particularly in low- and middle-income countries?

All stakeholders involved in identifying, planning, funding, implementing, monitoring and evaluating the HPS approach will find some answers in this publication, which summarizes the experiences of eight countries spread across the world.

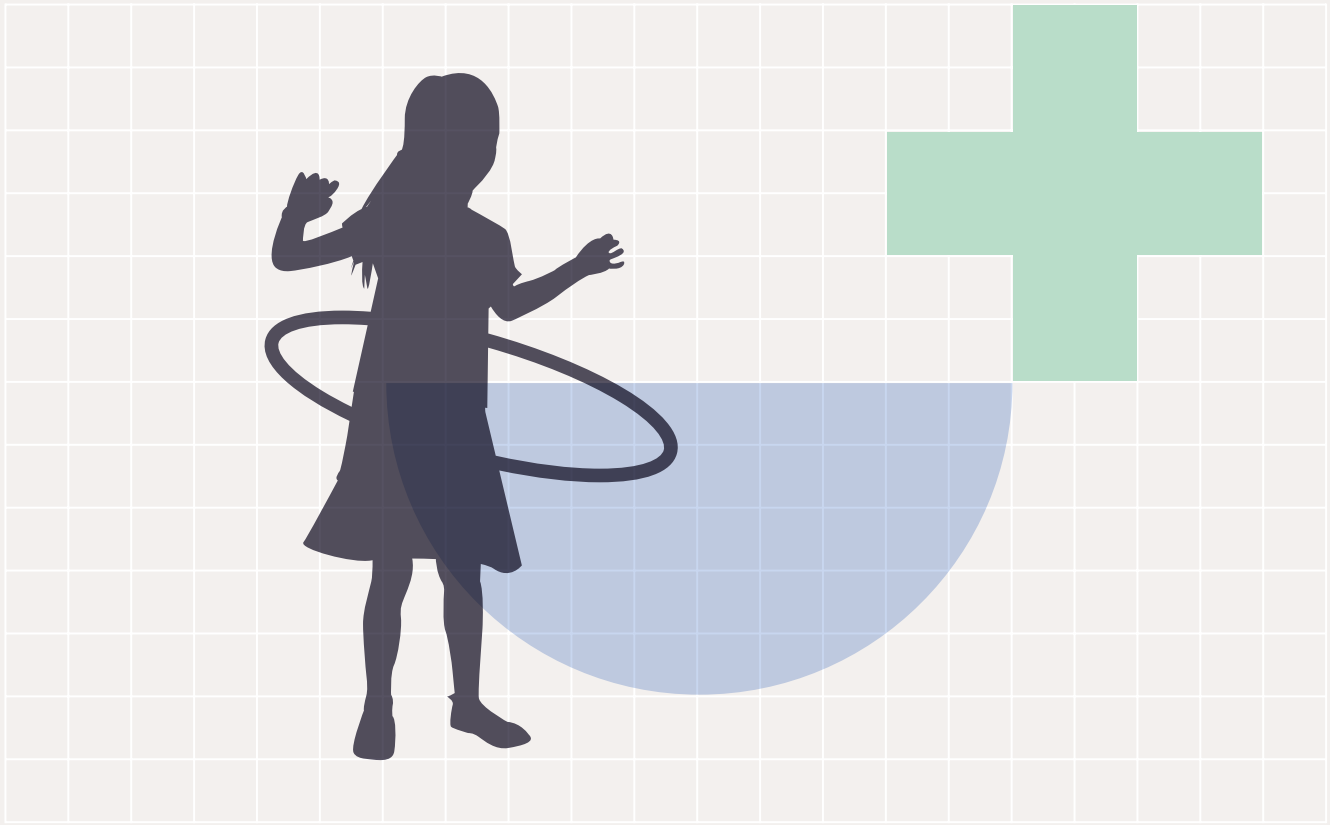
Towards making every school a health-promoting school: Be inspired by the experiences of others.

Health Promoting Schools are everyone's business.

This requires multi stakeholder engagement.

Introduction

Schools are settings in which students acquire the knowledge, attitudes and skills that provide a foundation for future education and employment, as well as health and well-being. A health-promoting school is "a school that constantly strengthens its capacity as a safe, healthy setting for living, learning and working" *(5)*. The aim of a health-promoting school is to promote health by capitalizing on the organizational potential of schools to foster the physical, social, emotional and psychological conditions for health, which also underpin positive education outcomes *(17)*. While HPS and other whole-school approaches to promoting health in schools have been used for several decades, it was recognized recently that the uptake and sustainability of HPS should be improved *(18–20)*.



In 2018, WHO and UNESCO announced an initiative for the development and promotion of global standards and indicators for HPS and their implementation. The initiative is expected to serve over 1.9 billion school-aged children and adolescents and will contribute to attainment of the target of WHO's 13th General Programme of Work of "making 1 billion lives healthier" by 2023 *(21, 22)*. The initiative will also support attainment of the United Nations Sustainable Development Goals for both education and health, including the target "all learners acquire the knowledge and skills needed to promote sustainable development … human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity …." by 2030 *(23)*. The current challenges and disruptions to education caused by COVID-19 highlight the need for investment in inclusive, equitable education to address learning disparities and build human capital *(24)*.

Within this initiative, WHO and UNESCO commissioned two reviews to form the basis of new global standards for HPS. The first review was a snapshot of global policies, standards and guidelines for HPS or similar whole-of-school approaches *(19)*. The second was a systematic review of the evidence on enablers of and barriers to the uptake and sustainability of HPS *(18)*. The reviews identified gaps in contextual understanding of the implementation of HPS in low- and middle-income countries (LMIC), which was considered important for informing global guidance on HPS. Accordingly, WHO and UNESCO commissioned eight country case profiles.

Aims

The purpose of the profiles was to identify the barriers to and enablers of health promotion in schools in LMIC for global guidance on HPS *(25)*. Focusing on LMIC also enabled identification of the issues in implementation of HPS in these countries, which could then be addressed by implementation guidance, where possible.
The purpose of the case profiles was not to assess or evaluate implementation of HPS in the countries but to explore:

1

the **types of collaboration** among different organizations, sectors, schools and the local community in setting policies for HPS

2

governance, monitoring and accountability practices and resource allocation models for health promotion in schools, government and other organizations

3

the **relations and roles** of government, other organizations and schools in day-to-day implementation of HPS

4

lessons from implementation of HPS to inform implementation guidance for HPS *(19, 25)*

The findings from the eight country case profiles are described, with the procedures used to collect the data for the profiles.

Methods

Potential LMIC for the study were identified by WHO and UNESCO by consultation with their country offices, stakeholder groups and networks, which also identified key informants. Case countries and key informants were selected by a "purposive convenient sampling" technique, and the choice of countries was based on the following criteria:

- representation of the six WHO regions (African, Americas, Eastern Mediterranean, European, South-East Asian, Western Pacific)
- known and/or demonstrated implementation of HPS or related health–education policy
- key informants who currently held government positions in health or education departments or ministries in the countries
- English-, French- or Spanish-speaking countries, decided pragmatically by the WHO–UNESCO team within the terms of reference of the work and consistent with previous reviews

Recruitment of key informants

Fifteen key informants in the eight selected countries were identified by WHO and UNESCO and invited by email to participate in a video conference interview with the research team. The invitation and questionnaire were available in English, French and Spanish (see Annex 1). Nine of the invited informants agreed to participate (Table 1).

Table 1. Case profile countries and key informants

Country	WHO Region	Organization	Language of interview
Bhutan	South-East Asian	Ministry of Education	English
Indonesia	South-East Asian	United Nations Population Fund (UNFPA)	English
Paraguay	Americas	Ministry of Health	Spanish
Philippines	Western Pacific	Ministry of Education	English
South Africa	African	Ministry of Education	English
Senegal	African	Ministry of Education	French
Tunisia[a]	Eastern Mediterranean	Ministry of Health	French
Tunisia[a]	Eastern Mediterranean	Ministry of Higher Education	French
Ukraine	European	WHO Country Office	English

[a] Two key informants from Tunisia participated in individual interviews.

Data collection and analysis

Data for each country were collected from three sources:

- an online questionnaire;
- publicly available policy and programme documents for each country; and
- interviews with the key informants by video conference.

Data collection and analysis procedures for each source are summarized below. Written informed consent was provided by each key informant.

Online questionnaire

A short online questionnaire in English, French or Spanish was distributed to key informants as part of the invitation to participate (Annex 1). The questionnaire elicited descriptive information about HPS or related health and education policies in each case country to facilitate questioning of the informants during the interview. The questionnaire also invited informants to identify publicly available documents that provided further information about HPS or related health or education policies.

Policy and programme documents

The key informants were asked to suggest policy or programme documents that included:

- a definition of HPS (or related whole-school approach) and school health more broadly;
- resources allocated to implementing HPS and school health;
- government involvement in implementing HPS and school health (e.g. ministry, role);
- involvement of other organizations in implementation of HPS or school health (e.g. type of organization, role);
- components of the health education curriculum;
- school physical environment standards and guidelines;
- school social, emotional and environment standards and guidelines;
- involvement of the local community in schools; and
- monitoring and evaluation of HPS and school health more broadly.

The documents identified by the key informants underwent a structured content analysis, and information on each of the above areas was extracted.

Interviews

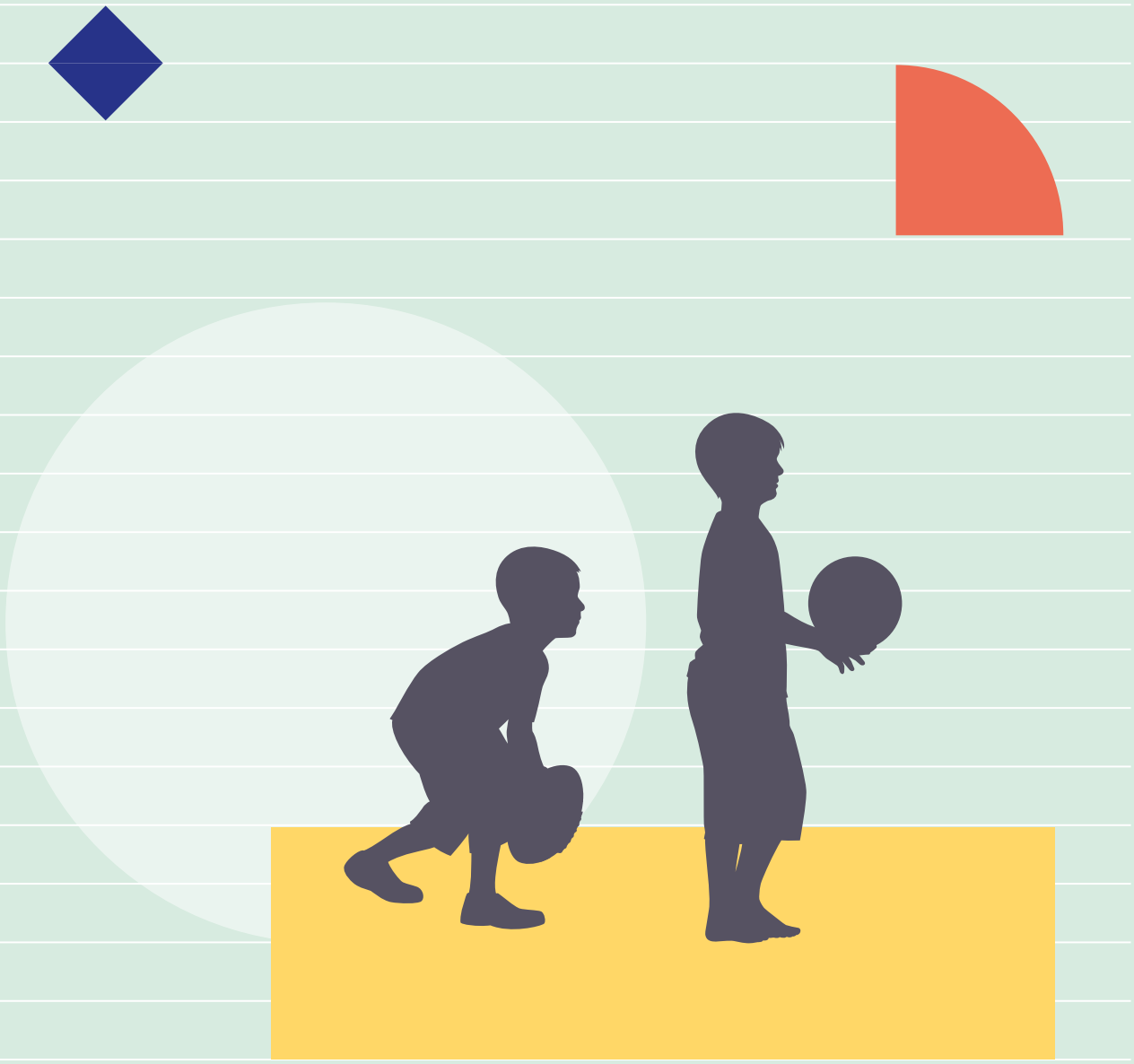
After receipt of the completed online questionnaire, an interview was conducted by an interviewer with expertise in semi-structured interviewing, case study methodology and global policy and programme evaluation. Each interview was conducted in the interviewee's preferred language and guided by a semi-structured questionnaire. The informants were encouraged to provide additional information about implementation of HPS or related health or education policies in their countries, with contextual factors considered to influence the health and education of students and local communities. The interviews lasted up to 90 minutes each.

Each interview was audio-recorded (with the consent of informants) and transcribed verbatim, and each interview transcript was then analysed by the interviewer. This obviated translation and back-translation, as the interviewers analysed interviews conducted in their languages.

The questionnaire, interview and documentary data were then combined and analysed in a general inductive approach, entailing multiple readings and re-readings of transcripts and identification of common themes *(26)*. The themes were then organized into categories according to their relation to one another and in order to draft consistent case country profiles.

All the quotations in the case profiles are from key informants.

Case profiles



Bhutan

Bhutan is a country in South Asia with a population of 735 553, of whom 185 000 (24%) are of school age (5–18 years). The educational structure in Bhutan comprises 11 years of free basic education in classes PP to X, with 7 years of primary education (PP–VI), which starts at the age of 6, and 4 years of secondary education (VII–X). The 2019 net primary enrolment rate was 92.9%; 91.2% of all 6–12-year-olds were enrolled in the primary education programme *(27)*. As of 2019, 9279 teachers were practising in 529 schools, most of which were public (491) *(28)*. The official language in Bhutan is Dzongkha, although English is the medium of instruction in schools and is also widely spoken.

How is HPS defined and applied in Bhutan?

The key informant reported that HPS "has a wide range of definitions" and is understood variously in the country. The term "health-promoting schools" is not commonly used; promoting health in schools is often referred to as "school health". The term HPS is, however, being used more often, for instance in the most recent national school health promotion plan *(29)*.

As detailed in the plan and the draft National Education Policy and verified by the key informant, it is recognized in Bhutan that schools have a significant role to play in the health of students. **"Health is considered [a] primary concern, particularly when it comes to [the] health of children in early childhood care centres and students in the school."**

School health policies and practices in Bhutan involve all of the following areas, exemplifying a holistic view of health and well-established recognition of the importance of embedding health in educational curricula and teaching (pedagogy):

- provision of water, sanitation and hygiene (WASH) facilities and promotion of healthy practices;
- nutrition programmes, including the provision of nutritious meals;
- safe schools and child safety, including the physical, social and emotional safety of students and school staff, disaster response, anti-bullying, ban on corporal punishment and inculcation of a positive school culture;
- promotion of games and sports (physical education) for health, including a structured curriculum, apart from extracurricular activities and competitions;
- psychosocial well-being, including trained counsellors to provide services and life skills education;
- supporting students to become citizens in the 21st century by understanding Bhutan's national identity, cultural and spiritual heritage and the values and principles of "gross national happiness" *(30)*; and
- a gender-responsive curriculum and pedagogy, with a specific requirement that school environments be gender inclusive.

What are the organization and infrastructure of school health in Bhutan?

The Royal Government of Bhutan leads implementation of school health through national policies and implementation plans and by allocating resources to local governments (districts and municipalities[1]) and schools for education and school health. Given the role of the Government in development of curricula, policies and allocation of resources, there is usually little variation in education provision between primary and secondary schools or by region, according to the key informant. There are, however, local plans and programmes involving district and municipal education offices. Depending on the focus of the plan, some involve development partners.

"UNICEF and Save the Children International support in areas of child care and development, disability and WASH, while UNFPA support[s] adolescent girls' education and health, and WFP [World Food Programme] [in some areas] for school feeding."

Innovation is encouraged, and schools, community organizations and district and municipal education offices are asked to share ideas, such as at education conferences and the biannual national education conference.

Who is involved in school health?

National and local government

Both the Ministry of Education and the Ministry of Health are directly involved in school health and **"work together from the political perspective to take into consideration the health and education of all"**, including inclusive curricula and pedagogy. The involvement of the Ministry of Health depends on specific health needs and policy priorities. For instance, the Ministry of Health currently has a considerable role in deciding on infection control in schools, to limit exposure to COVID-19, while the Ministry of Education ensures that all schools follow the preventive measures.

Other national Government departments that are involved in school health include the Ministry of Finance for resource allocation, the Gross National Happiness Planning Commission and the Royal Civil Service Commission for planning human resources. They are involved when an aspect of school health falls within their responsibilities.

District and municipal education offices are directly responsible for implementing national education policies and plans in schools in their areas, including monitoring implementation and, when appropriate, conducting more detailed evaluations. For instance, the WASH in schools programme is monitored by local governments with support from development partners (e.g. UNICEF and UNFPA).

Development partners

Development partners include the Government of India, UNICEF, Save the Children International, Helvetas, UNFPA and the WFP. These organizations support schools and district education offices in implementing national policies, particularly when the policies include a reference to international programmes or are aligned with international guidelines and programmes (e.g. WASH). The role of development partners is to provide technical, budgetary and capacity-building assistance for school and Government staff members. The assistance and involvement of development partners is based on the National Education Plan and priorities.

Local schools and communities

Within school communities and schools, school health is implemented primarily by school leaders and teachers, and the important role of teachers in student health and well-being is recognized: **"Teachers are highly regarded by the children and parents, and they play a second parent role in most schools, particularly in boarding schools."**

Parents and caregivers are also involved in aspects of school operations, particularly in small schools, such as in developing and maintaining provision of water and sanitation. The degree of involvement of parents and caregivers appears to depend largely on the circumstances and requirements of the school and the wider community. Thus, involvement is based largely on need rather than specific policies at the school, district or country.

Monitoring and evaluation of school health policies

School health policies and specific programmes, such as school feeding, are embedded in the education system, and they are monitored by the School Health and Nutrition Division and Education Monitoring Division under the Department of School Education in the Ministry of Education.

Information from monitoring is used mainly to make decisions about policy and resource allocation. It may also be reflected in reports on education system performance, such as in annual education statistics, including monitoring of universal access to safe water and sanitation facilities in schools.

Impact of school health policies

The key informant indicated that widespread implementation of school health policies in Bhutan has resulted in improvements in student health.

"The health of the students has improved drastically [such] that the reported cases of stunting, malnutrition and disease outbreak among school children has decreased significantly. The gender parity has improved, and many of the students have taken lessons from the HPS programmes back to their homes in the villages, as a result of which water, health and sanitation has also significantly improved in the communities, and is picking up."

Much of the success was attributed to implementation of specific health programmes. The key informant indicated that school health policies should now diversify beyond the current dominant programmatic focus to be more broadly responsive to the needs of students. HPS was viewed as an opportunity for professional development that would reflect the wider roles of schools in promoting health, with the involvement of the wider local community.

[1] There are 20 districts (*dzongkhags*) and 4 municipalities (*thromdes*).

Barriers to implementation of school health policies

Lack of sufficient, sustained human and financial resources was reported as a barrier to implementing school health, although the current National Health Plan includes a broader, more holistic commitment to school health than earlier plans. According to the key informant and as reflected in the National Education Blueprint *(31)*, resources for school health were previously allocated mainly to specific programmes (e.g. WASH). This approach might require modification, as the programme involves a whole-school approach to health.

Another barrier to implementing school health was the variable capability of those involved, including school leaders and teachers. The key informant indicated, for instance, that more technical assistance might be required for government and school staff.

Enablers to implementing school health policies

Three factors were reported as sustaining implementation of school health in Bhutan. First, the small population of the country and the one system of governance were reported as advantages in national implementation of a whole-school approach. **"We have the advantage of a small system … under one leadership of His Majesty the King, and one governance."**

Secondly, successful implementation of a range of school health programmes has led to full adoption of many, supported by trained, competent staff. It was considered that teachers and school leaders can draw on these positive experiences to inform implementation of broader whole-school approaches to promoting health.

Finally, the existence of a National Education Policy *(30)* and implementation guide was viewed as a key enabler, as they give a clear policy directive for diversifying current school health programmes, recognition of the value of health in education and a reflection of broader objectives for achieving the Sustainable Development Goals. For example, **"The National Education Policy also emphasizes the need to promote and mainstream gender equality across all levels of education"** [aligned with Goals 4 and 5],

The key informant indicated that legislation (e.g. an act) could strongly support nationwide school health implementation.

"While much has been done, the challenges still remain in reaching the last mile. In the context of mainstreaming HPS, there is a need to have legislation outlining the national commitment and resource allocation to ensure consistent and sustainable upscaling of the HPS."

Sustainability of school health policies

The national commitment to school health in Bhutan is guided by a 10-year road map, the Bhutan Education Blueprint 2014–2024 *(31)*. The National Education Policy also includes a 5-year plan, with **"clear goals and expectations for the education sector [as well as] work with external agencies and development partners and planning commission on the areas for interventions"**, which suggests that school health policies will be sustained.

The key informant considered, however, that school health policies would be viable only with dedicated, sustained financial resources and capacity-building for teachers and school leaders beyond the current school health programmes, which are delivered largely by development partners. The key informant clearly acknowledged that extending the reach of school health and HPS would be strongly supported by legislation that clarifies **"the national commitment and resource allocation to ensure consistent and sustainable upscaling of the HPS".**

Infection control practices to respond to COVID-19 were referred to as an example of the need to scale up and invest in developing the capacity of school staff, which could have benefits beyond the pandemic.

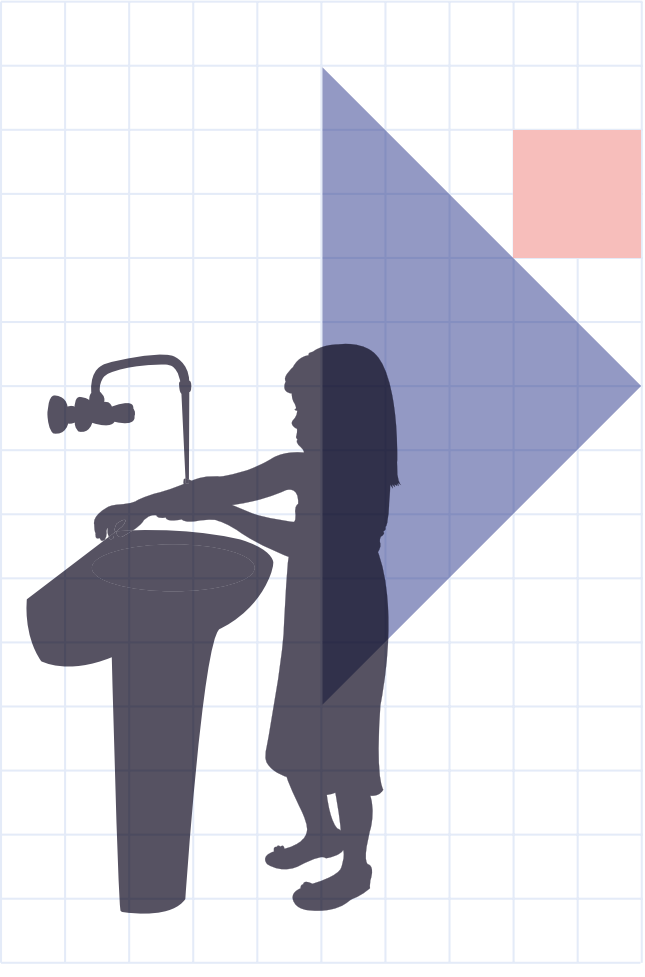


Table 2. Summary for Bhutan

Key features of school health organization

- Policy was developed by Ministry of Education and Ministry of Health (other Government departments are involved in resource allocation according to their portfolios).
- Local governments (district education offices) are responsible for implementing national education policies in districts.
- Development partners support schools and district offices in implementing national policies, particularly those aligned with international programmes. The partners include the Government of India, UNICEF, Save the Children International, Helvetas, UNFPA and WFP.
- School health policies and programmes are implemented relatively uniformly in all regions.

Implementation barriers

- Insufficient human and financial resources hinder the sustainability of school health initiatives.
- Variable capacity and capability of school staff hinder progress from programmatic to whole-school approaches to health.

Implementation enablers

- A small population with one national education system.
- Experience in implementing successful school health programmes.
- Long-term (10-year) policies that highlight a commitment to whole-school approaches to promoting health, including the National Education Policy and implementation guide and the National Education Blueprint.

Impact of school health policies

- Student physical health has improved over time, attributed in part to successful implementation of specific health programmes.

Sustainability of school health policies

10-year road map (Blueprint):

- Sustained financial resourcing.
- Broader capacity-building and embedding school health throughout the education system

School health and HPS reach:

- National commitment and resource allocation to scaling up HPS
- Infection control during COVID-19 offers opportunities to embed school health policies, such as more hand-washing stations, safe drinking-water and toilet facilities, in all schools.

Indonesia

Indonesia is an archipelago nation located in South-East Asia. With a population of 274 million, 65.8 million (24%) of whom are of school age (5–18 years), Indonesia is the fourth most populous nation in the world *(32)*. While formally a "unitary republic", Indonesia effectively grants considerable autonomy to provinces such as Aceh (Sumatra) and Jakarta (Java) and other areas, including Papua and West Papua. Nevertheless, the education system remains centrally governed by the Ministry of Education, which is responsible for developing curricula, hiring teachers and school examinations *(32)*. Education is compulsory and provided free of charge at public schools from grades one to nine. In 2010, 80% of elementary schools were public. Private institutions play a more significant role at secondary level, comprising 57% of lower secondary schools and 70% of upper secondary schools, even though the majority of students were enrolled in the public institutions *(32)*. Religious schools, in which teachers deliver a combination of the national curriculum and specialized religious studies, comprised 15% of private institutions in 2014.

How is school health defined and conceptualized in Indonesia?

In Indonesia, the approach to promoting health in schools is referred to as *usaha kesehatan sekolah* (UKS) (activities for health and well-being in school). School health promotion is referred to in this policy and is considered to be holistic, including fostering a healthy school environment and provision of health education and health services. UKS began in Indonesia in 1980 and was updated in 2003 and 2014 *(33)*. The approach is based on existing health **"infrastructure and networks of HPS including referral to youth friendly services and primary health centres"** and includes initiatives for the well-being of adolescents.

The 10 provisions of UKS range from mental health screening and immunization to teacher training and embedding health education in all curricula and subjects. While UKS is broad and holistic in terms of the components of health promotion that it includes, the key informant indicated that the process and understanding of how the components can be integrated into a whole-school approach is still being conceptualized:

"... there is this framework of [a] healthy school. But of course, what is missing is this implementation of this framework, so only one school implements one bit and we don't really know how to implement it as a whole model ...."

The term "health-promoting schools" is often used to refer to school health in Indonesia, and there is a nationwide competition for recognizing and awarding health promotion activities in schools.

"So far the perception that health should be part of education by the 'UKS' programme is usually quite general and every school knows about it, including teachers, associations and so on ...."

What are the organization and infrastructure of *usaha kesehatan sekolah*?

The infrastructure of the UKS and all associated activities are the responsibility of four ministries: health, education, religious affairs and internal affairs. Some form of health activities is mandatory in all public and private schools; however, this is difficult to ensure, because school management is relatively decentralized.

"... we cannot mandate that every school including private and public schools, does the activities of a health promoting school, what [we] can do is suggest to governors that these should be part of their priorities ...."

The infrastructure is ensured by the joint secretariat for health in schools. The secretariat is currently based in the Ministry of Education, but it leads joint planning and activities in all four ministries. The secretariat also suggests health promotion activities in schools to the governors of regions. **"The policy infrastructure is pretty robust for HPS, with high-level commitment."**

Most funding for implementing UKS is from what is referred to as "a special allocation", in which financial resources are pooled and distributed and managed by districts or local governments, which have their own budgets. Additional funding may be provided by the national Government for certain priorities or according to need in specific areas; such funding is referred to as "special transfers".

"'Special transfers' is different from the health side, and it's different from the education side. So, to think about funding it as one channel, mostly education has more money than health so to find who funds what, what is the division and what's the guidance for that financing. Often people don't think about that. I think about that a lot because financing is a huge problem like who, how and that's very specific to Indonesia …."

Funding for UKS tends to be based on the nature of the activities in schools. For example, funding for mental health may be available from specifically allocated funds.

To encourage schools to participate in UKS, there is a nationwide competition for health promotion in schools. The competition is well known and respected in the broader community, and winning the competition is considered an indicator of a high-performing school.

"… this competition is widely acclaimed, and schools are so proud, and it's become kind of like 'If I win this competition, I am a better school than the other schools', and that's how they market their schools."

In every school district in Indonesia, a working group is responsible for monitoring the progress of health promotion in schools and selecting schools in the nationwide competition. The working groups are based in district health offices. They include members of the local community and work with the heads of villages. They also support schools in embedding health promotion in the local community.

"One time there was a child with HIV/AIDS rejected from a private school, and the school community tried to reason with the school, and they [the working group] solve problems like that."

Who is involved in school health?

Many organizations and agencies are involved in implementation of UKS.

National government

The Secretariat of Health in Schools provides the joint regulatory infrastructure for the Ministry of Health (which continues to be involved in the development and implementation of UKS), the Ministry of Education (which is also involved in development of UKS, supports school funding and houses the secretariat), the Ministry of Internal Affairs (which collects some data on indicators of child and adolescent health) and the Ministry of Religious Affairs. The Ministry of Child Protection also supports implementation of UKS, as it is responsible for implementation of "children-friendly cities and child-friendly districts", in which some policy implementation overlaps with UKS.

Local government

District offices, and specifically working groups for UKS based in district primary health care offices, are responsible for supporting and monitoring the progress of schools in implementing UKS. One office manages up to five or six schools in its area. The working groups include members of the local community and school staff. Most engage with school principals and other school staff with responsibility for school health promotion. A key aspect of the support is encouraging changes in norms in schools and supporting school policies aligned with the UKS: **"… the working group is quite useful for changing norms in schools and interventions for changing norms and certain things within schools."**

Development partners

As noted earlier, a number of development partners support UKS. WHO supports not only policy development but also youth-friendly health service interventions; UNFPA supports the development of strategies for adolescent health; and UNICEF currently works with district offices to support pilot programmes to strengthen school health promotion and embed inclusive education and life skills education (under "character education").

Schools and local communities

Schools and local communities are directly involved in UKS implementation, predominantly in activities for which the indicators are monitored by primary health district officers. Examples include the provision of screening in school-based or school-linked health services and immunization programmes. While private schools also implement UKS and volunteer to participate in the HPS competition, they are not managed directly by district primary health offices.

Monitoring and evaluation of *usaha kesehatan sekolah*

Mandatory indicators of child and adolescent health are monitored directly by district primary health offices, as noted above. In the national Government, monitoring and evaluation tend to be the responsibility of the Ministry of Internal Affairs and other ministries in the joint secretariat.

Monitoring and evaluation tend to be conducted for specific health topics or issues. Although the National Development Plan includes a "youth development index", with five domains (including health, education and gender), certain specific indicators, while informative, do not necessarily provide a comprehensive picture of UKS implementation in schools.

"The number of school-aged children screened for health services is a mandated indicator across all the districts in which every district health office must report to the Ministry of Internal Affairs, but that is only one component of Health Promoting Schools and that is gathered by the district health officers …."

The lack of comprehensive monitoring is partly explained by inadequate monitoring tools for what was referred to as "joint indicators", i.e. indicators of collaborative, mutually reinforcing activities that schools may engage in when implementing UKS. It is also perhaps due to the absence of detailed guidance for implementing UKS as an overarching model of health promotion.

"What is the big problem with character education is that they don't have proper monitoring tools, what to do, how to change teachers and so on … they are struggling to measure it, at least in the education sector … how do we [capture what] is measured in national demographic surveys and we need to think about that and that is part of the difficulty of finding a joint indicator where everybody contributes."

Barriers to implementing *usaha kesehatan sekolah*

A number of barriers to the implementation of UKS were reported. Some reflect broader challenges of HPS in general.

The first barrier specific to Indonesia was the proportion of and model for allocating resources suitable for increasing implementation of UKS. Use of the "special allocation", while not problematic, tends to be based on inconsistent guidance in use of funds for HPS, as it is organized according to a "set of menus", which may be based on topics, e.g. mental health. Further, the allocation method involves pooling money and management of budgets by districts, so that it may be difficult to determine whether sufficient resources are provided for health promotion in schools and whether schools can appropriately and equitably access funds according to their needs; **"… there are huge gaps in delivery itself, that this is what we know and scaling up these other strategies to think about financing …."**

Similarly, it is unclear how much support there is for implementation and how it should be delivered. Although district health offices are involved in managing schools that implement UKS, because of the way in which their role is organized and the distribution of primary health centres within and across districts, some schools are outside the jurisdiction of a district health office.

"It is also not clear whether the duty of the primary health centre is only within their jurisdiction or within that district or [even] what's the division, so you can have some schools miss out because of different ways schools are managed."

Significant restructuring of Government ministries was reported as a barrier to sustained progress in the implementation of UKS, which was also due to unclear roles and responsibilities.

A broader barrier to implementation of HPS in Indonesia was lack of a shared conceptual framework. The design of UKS, while holistic in its conceptualization of health in education, does not include a clear model or framework for overarching implementation of HPS. The key informant considered that this might be due partly to lack of a conceptual framework that could be shared with development partners and United Nations organizations to ensure integration of intersectoral work. In Indonesia, this contributes to lack of clarity about roles and responsibilities and to siloed health promotion that is programmatic rather than strategic, without a whole-school approach.

"... for instance, the WHO think about it [health promotion in schools] as prevention of something, even [for] adolescents, in a very developmental [way], whilst child protection think of it as child rights and they do not really speak with each other including in terms of selection of indicators."

"People follow different interventions and indicators in different ways [...]. There [are] all these different people working with that target group with all these different ways in which they conceptualize how [to intervene on the health of] adolescents ...."

Another important barrier was described as lack of evidence-based research on effective implementation, funding, monitoring and evaluation of HPS at scale in middle-income countries.

"... we don't have good evidence of what actually works, but outside that there should be a science of scaling up and how we look at funding allocations, and that it is a specific science that we need to look at, not in really poor countries but in middle-income countries."

The key informant noted that in Indonesia (and beyond) there is concern about how the progress of HPS will be affected by the COVID-19 pandemic, particularly if education becomes increasingly focused on academic outcomes.

"Part of the complaints from the Ministry of Education during [this] COVID time [is that] all [of] this is not happening ... all the teachers and people in the field almost all say [that] this year, young people will not get any formal life skill education or any health promoting benefits."

Enablers for implementing *usaha kesehatan sekolah*

Three enablers for implementation of UKS were reported. First, the design of the teaching curriculum and pedagogical approaches to health education have improved and potentially increased the overall quality of teaching.

"They have a programme now also on improving pedagogical methods of teaching, and we have used that programme to talk about life skills, because you need special pedagogical methods like participatory pedagog[y]. So, they have a programme that has increased the quality of teaching in terms of pedagogical methods and so on."

Secondly, the decentralized approach to implementing and managing UKS in schools can facilitate use of local resources and strengths to ensure successful UKS in districts. In combination with the establishment of regional HPS networks, practices that contribute to success can be shared within the district and with other districts. Over time, building relationships can contribute to the establishment of larger networks throughout the country to support and contribute to scaling up of UKS.

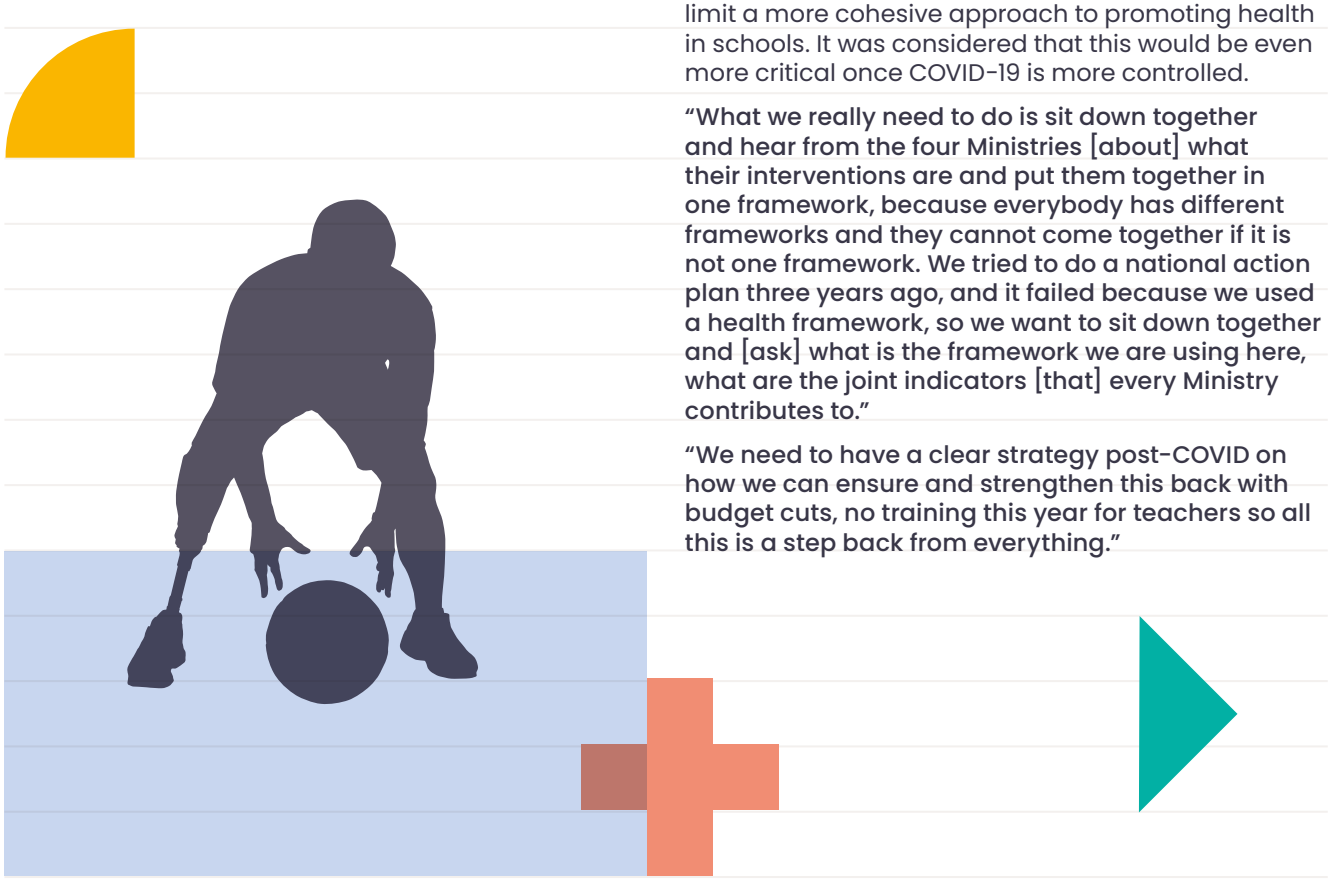
"If we look at what's relevant to the people who make decisions within the community and we find their selling points, document it and help them with knowledge management, the other districts use their own money for them to be trainers in their district, and actually we had 16 districts use the first district as a trainer, and then we said ok we need to have a national meeting, and that's how scale up happens, and I do believe that if you start with one community that can happen".

Impact of *usaha kesehatan sekolah*

The impact of UKS implementation was considered uncertain: **"… only certain aspects of it are mandated, and when we say 'mandated' we don't really know if it is implemented; it is impossible to know if there is 100% implementation."** Similarly, the absence of appropriate monitoring tools was reported to make evaluation of the impact of the UKS policy difficult. The key informant noted, however, that the prestige associated with the nationwide competition for the best HPS indicates its value and the perceived worth of implementing UKS in schools and local communities in Indonesia.

The ultimate measure of impact is the empowerment of young people to participate in health promotion and to make informed decisions about their health in the longer-term.

"For me personally, I would like young people know that what is done for them is for (them) and [that] they take part … really addressing what they need and with the understand[ing] that they participate in their own well-being so, that is what I envision … I think that's the key – that young people really feel they go to school, they go to health screening, they go to health services – that its actually for them and not for when they grow big and not for their parents but for what they want for themselves, and they make those decisions. I think that for me is the most important part of it."



Sustainability of *usaha kesehatan sekolah*

A strategy to improve and increase the sustainability and scalability of UKS in Indonesia would address many of the barriers listed above. For instance, improving the specificity and detail of implementation approaches and strategies for UKS, particularly in teacher competence, which extend to pre-service teacher education and in-service professional learning, would improve the sustainability and the effectiveness of UKS.

"… the school health model, this is also part of the interventions including teacher competencies … the Ministry of Education should explicitly have a strategy [about] how to build competency in service and pre-service terms of teachers."

The key informant considered that a stronger, more targeted focus on gaining the influence of local communities, teachers and principals to build commitment and ownership of UKS was likely to effect positive change and support sustained action.

The key informant's main suggestion was to conduct research on implementation and design in order to inform policy development for UKS. More detailed guidance on appropriate financing and a process for effective intersectoral collaboration should be sought to address some of the challenges associated with the lack of clarity in roles and responsibilities, insufficient resources and missed opportunities for implementing health interventions, which currently limit a more cohesive approach to promoting health in schools. It was considered that this would be even more critical once COVID-19 is more controlled.

"What we really need to do is sit down together and hear from the four Ministries [about] what their interventions are and put them together in one framework, because everybody has different frameworks and they cannot come together if it is not one framework. We tried to do a national action plan three years ago, and it failed because we used a health framework, so we want to sit down together and [ask] what is the framework we are using here, what are the joint indicators [that] every Ministry contributes to."

"We need to have a clear strategy post-COVID on how we can ensure and strengthen this back with budget cuts, no training this year for teachers so all this is a step back from everything."

Table 3. Summary for Indonesia

Key features of school health organization

- School health promotion is delivered through the UKS strategy in public and private schools in Indonesia. It is mandatory for all schools to implement health promotion.
- UKS consists of 10 components, ranging from mental health screening and immunization to teacher training and embedding health education in curricula and subject areas.
- Funding, management and monitoring of progress are done in district health offices.
- There is a national annual competition for the best HPS, which is considered highly prestigious.

Implementation barriers

- The resource allocation model for implementing UKS is unclear and may differ by district.
- There is limited policy guidance on implementation and for organizing UKS health promotion activities.
- There is limited evidence on effective implementation practices and strategies in middle-income countries.
- There is a risk that the priority of school health promotion activities will be downgraded by the disruption in schooling due to COVID-19.
- Limited monitoring and evaluation tools are available for holistic implementation of UKS (i.e. strategic rather than programmatic implementation).

Implementation enablers

- The extent to which UKS is implemented in teaching curricula and pedagogical approaches in health education (life skills and character education) was considered valuable.
- Decentralized approaches to implementing UKS can improve understanding of and focus on capitalizing on the strengths of schools and local communities.

Impact of school health policies

- This was difficult to determine because of limited appropriate tools for monitoring and evaluation.
- The nationwide competition for best HPS has significant prestige in Indonesia.

Sustainability of school health policies

- Greater focus on improving teacher competence in pre-service education and in-service professional learning would improve the sustainability of UKS and also the quality of teaching in general.
- Clearer policy guidance on implementation would improve the sustainability and scalability of UKS throughout Indonesia.

Paraguay

Paraguay is a country in Latin America with a population of over 7 million, of whom 2.03 million (26%) are of school age (5–17 years) *(34)*. The two official languages in Paraguay are Spanish and Guarani *(35)*. Education begins at the age of 4 with nursery and preschool, then 9 years of basic education consisting of three cycles and another 3 years of high school, in which students choose to pursue a scientific baccalaureate or a technical degree.

How is the healthy school strategy defined and conceptualized in Paraguay?

In Paraguay, school health is ensured through a healthy school strategy (*estrategia escuela saludable*) (HSS), a comprehensive whole-school approach to promoting health, which is intended to contribute to development of the health potential of children, with the school as a strategic environment for promoting a culture of health that then radiates to the community. The HSS is based on a situational analysis of the basic needs and potential of each participating school. Thus, there is no a pre-established plan but rather one adapted to the rhythm and progress of each school and community, with support from local, regional and national government departments of health, education and other sectors, and other stakeholders as appropriate.

The HSS emphasizes strengthening of intersectoral work. Such collaboration is considered critical to health promotion in schools as it ensures transformation of environmental conditions through an inclusive, reflective, proactive process and reinforces participation and leadership by members of the education and health sectors.

What are the organization and infrastructure of the HSS?

The HSS began in 1996, with a joint commitment from the ministries of Public Health and Social Welfare and Education and Science that led to a framework agreement with the WHO Regional Office for the Americas, signed in 1998. This led to a pilot programme supported by the Regional Office. Paraguay is part of the Latin American Network of Health Promoting Schools.

Implementation of the HSS in Paraguay is voluntary. Resources from national and local governments contribute to implementation of the strategy in each school; however, resources are generally allocated to individual health promotion activities rather than to the strategy as a whole. The strategy informs school curriculum development and is designed to enable implementation of regional government policies.

"The Misiones [regional area] department has a public policy on school lunches. All public schools have introduced the school lunch. All public schools receive a school lunch: local or regional government is responsible for building and maintaining the canteen, including recruiting and paying the staff (often, the mothers of the children), and the menu is established by a nutritionist and approved by the Ministry of Education and Sciences. The company awarded the tender must provide … fresh food from the locality where the school is located (often the parents of the students provide the fruits and vegetables)."

The strategy has four components:

- a comprehensive approach to health education;
- basic health, food and nutrition care;
- improvement of the physical and biopsychosocial environment; and
- social and community participation.

Implementation stages

Implementation begins with socialization of the strategy with the community of the school – the principal, teachers, students and parents. Once it is accepted, a management team is formed for implementation, made up of representatives of the school community, the departmental government, the municipality, institutions, community organizations and health professionals, ideally located in the community. They begin with a participatory situation analysis, including the basic needs, priorities and potential of the school. Thus, a pre-established plan is not imposed, and a plan is adapted to each school.

The strategy includes school accreditation by the Ministry of Public Health and Social Welfare and certification by the WHO Regional Office. A school is accredited when it is recognized as meeting the basic requirements of a "quality healthy school". For this, information is collected on implementation of health promotion activities according to the indicators listed in the HSS management guide *(36)*. An external party reviews the data and assesses the performance of the school according to the accreditation criteria to determine whether it meets the requirements and is achieving certain outcomes. If it does, the school is accredited. The school can then determine whether it will extend its implementation plan to a school-wide or whole-school approach to promoting health.

Certification, which occurs after accreditation, is public recognition that the school meets the criteria for a "quality healthy school", as detailed in the HSS management guide. The evaluation is conducted externally by the WHO Regional Office, which reviews and evaluates the work and grants certification. High-performing, certified healthy schools are those that sustainably reinforce the capabilities of schoolchildren and their environment and establish harmonious relationships among themselves and with others in physical, social and mental dimensions.

Currently, 280 schools in Paraguay are implementing the strategy; 88 have been accredited by the Ministry of Public Health and Social Welfare, and 8 schools have been accredited as healthy schools by the WHO Regional Office. The first indigenous healthy school in Paraguay, located in the region of San Pedro, was accredited in 2019.

Who is involved in school health?

As noted above, many organizations, Government departments, ministries and development partners, such as the WHO Regional Office, are involved in implementing the HSS in Paraguay. Their roles, responsibilities and collaborations are outlined below.

National Government

The General Directorate of Health Promotion in the Ministry of Health and Social Welfare is responsible for implementation of the HSS, jointly with the Ministry of Education and Sciences through the regional directorates of education and with the support of regional and local governments. Other ministries provide expertise according to the schools' action plans and their choices of health promotion activities. The ministries include those of Childhood and Adolescence and of Agriculture and Livestock.

Local government

Regional governments cooperate with schools in implementing national school policies. For instance, the "school snack and lunch" policy is led by the Ministry of Education and Sciences. Regional governments empower schools and local communities to implement and/or adapt and align school policies with national policies.

Development partners

A number of development partners provide technical support and funding for aspects of health service provision; e.g. funding from the Korea International Cooperation Agency supports implementation of the HSS in a district in the central region, while the WHO Regional Office provides certification.

Schools and local communities

Teachers and school leaders, representatives of parents, students, other members of the educational community and community members make up the healthy school management team, which is responsible for conducting a situational analysis and developing and implementing the action plan. Representatives of the community may include health professionals and departmental and local organizations such as the government, municipality, national police, volunteer fire department and private companies. Membership depends on the health promotion objectives of the school; for example, the police may be involved if one goal is to prevent violence. Parents and caregivers who are not on the healthy school management team are still expected to be part of implementation of the strategy at the school and to participate in planning, implementation and evaluation.

Monitoring and evaluation of the healthy schools strategy

The HSS is monitored and evaluated by national, regional and local technical teams in health and education, departmental and local governments, public and private organizations and the community on the basis of the indicators for accreditation and certification of the healthy school management guide. The WHO Country Office is responsible for monitoring and evaluation for certification.

Monitoring instruments have been designed and validated for use by HSS management teams in schools and by technical teams in health and education sectors to analyse progress, detect weaknesses and motivate reorientation towards achieving higher-level objectives. Progress is communicated publicly, and the results of evaluations are used to advance and further develop the strategy. Follow-up and monitoring of schools are considered crucial in Paraguay to identify strengths and areas for improvement, which can then be implemented locally by an actively involved HSS school management team.

Barriers to implementing the healthy schools strategy

Two main barriers to implementing the HSS were reported. First, resources are insufficient, mainly because there is no distinct budget for HSS, with funding only for specific activities. Similarly, human resources from the Government are limited to the staff required to accompany implementation and monitor the school's progress towards indicators for accreditation and certification.

"Ideally, we would have a focal person for health promotion [EES] in each district or locality to support the implementation and closer monitoring of EES. In some localities it exists, but not in all, and when it exists, the focal person also fulfils other tasks and responsibilities."

Secondly, notwithstanding the value of intersectoral action, the large number of national government departments involved in HSS was considered to be a barrier, especially for integrating different ideas into a coherent whole-school strategy. **"A challenge at times can be coordination and integration of directorates from different ministries involved in the implementation of HSS."**

Enablers to implementing the healthy schools strategy

A number of enablers were identified. First, detailed policies and the HSS management guide support implementation through a clearly defined, staged process, with monitoring indicators for each stage. The policies and management guide also ensure community participation in health promotion, as structures are included to support the participation of community members from the beginning of implementation, in planning and the situational analysis. The key informant reported that this has raised the status of the programme in the community and ensured ownership. **"The Healthy School Strategy in Paraguay is sustainable thanks to its intersectoral articulation and the appropriation of the Strategy by the whole educational community."**

Another enabler is non-monetary incentives for teachers for specific health promotion activities. The incentives are mainly in the form of resources. For example, in order to build compliance with physical activity standards, sports kits are awarded to targeted schools *(37)*.

Impact of the healthy schools strategy

The HSS has been in place for over 20 years, and its impact is widely considered to be reflected in improvements in school health and nutrition, fewer school dropouts, better learning, less violence, more job opportunities and strengthening of community agriculture.

"Now, we can perceive the difference when we visit a school, whether or not it is an EES school that implements the healthy school strategy, the difference is visible, even that extends to their homes and the community. For example, we hear parents say that children remind them to wash their hands and how to do it, learn to eat healthier foods, among other things."

Sustainability of the healthy schools strategy

When reflecting on the sustainability of the HSS in Paraguay during the past 20 years, the key informant said that intersectoral cooperation has been a critical aspect, although it could be strengthened further.

"To maintain [and] even strengthen the relevance of health in education and the relationship between the two in Paraguay, we should continue to strengthen the healthy schools strategy and formalize it through the updating of intersectoral agreements (Ministry of Public Health and Social Welfare, Ministry of Education and Sciences, Ministry of Childhood and Adolescence, among others), taking into account the comprehensive health approach and the approach to social determinants of health."

Increased support from ministries other than health and education was highlighted as necessary to the outcomes of the strategy, and it was suggested that inclusion of "an effective communication strategy" would enable this.

Significant community engagement and ownership in implementation were considered the reasons for the success of the strategy, which has been sustained for two decades.

"The fact that the healthy schools strategy has lasted for more than 20 years and has become a government policy in some localities where it has achieved greater results shows that, once the educational community incorporates the strategy into its dynamics, it sustains and consolidates it."

It was further reported that the sustainability of the strategy is attributable to active, continuous review and refinement, with consideration of the community, contextual issues and outcomes. Continued, scaled national implementation was reported to be the main goal of the strategy.

"Ideally, in 5 years, we would like to see the expansion of the HSS to more schools in the country. The greater the number of schools that implement the strategy, the greater the possibility that it will spread and consolidate at national level."

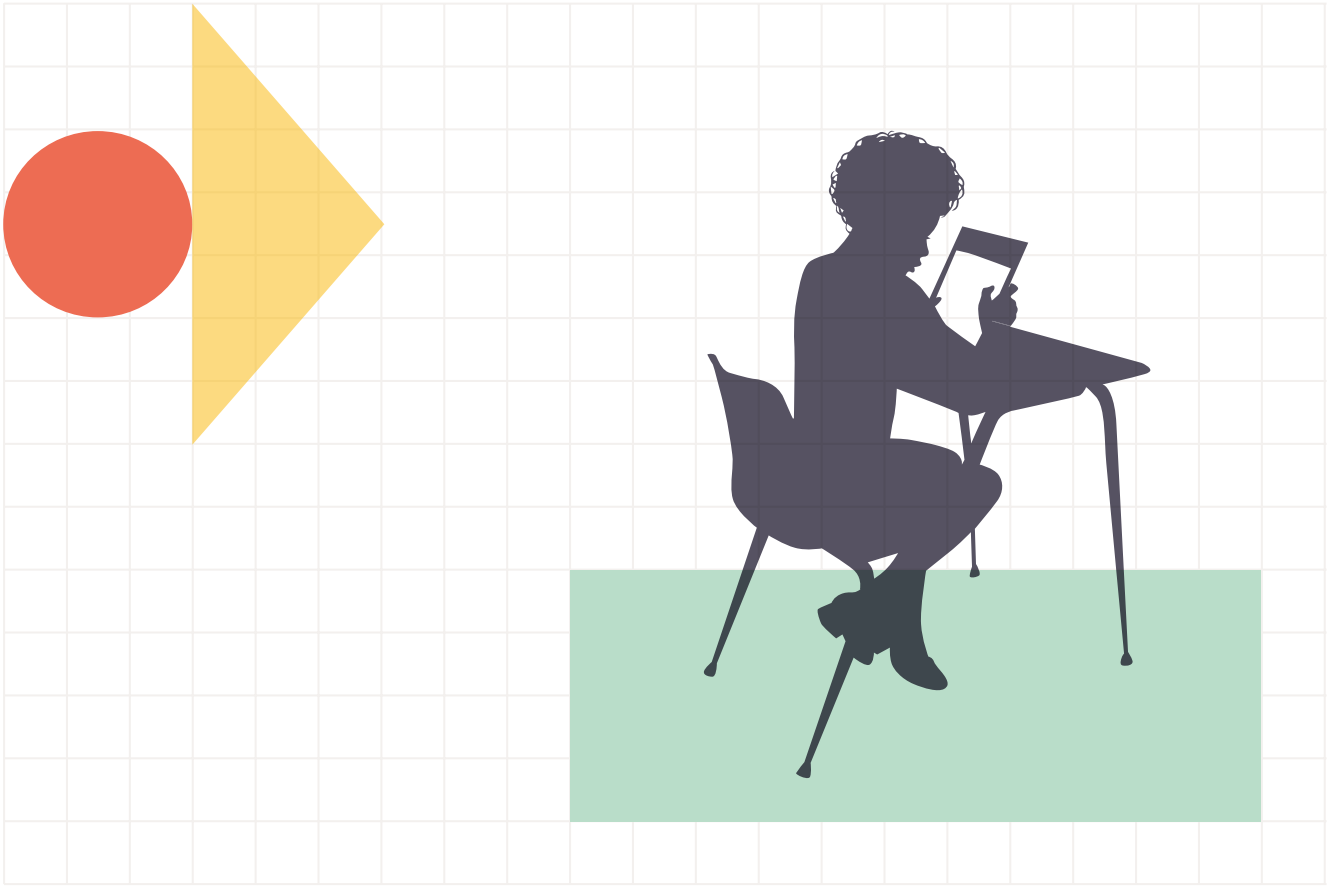


Table 4. Summary for Paraguay

Key features of school health organization

- School health promotion is delivered through the voluntary HSS in all schools in Paraguay. The strategy is led by the Directorate-General of Health Promotion at the Ministry of Public Health and Social Welfare, jointly with the Ministry of Education and Sciences and other ministries and institutions.
- The strategy has four components of health promotion: health education; basic health, food and nutrition; improvements to the physical and biopsychosocial environment; and social and community participation.
- The strategy is implemented in stages, with a guidance manual for the healthy school management team, which conducts a situational analysis and participatory planning, followed by accreditation by the Ministry of Health and Social Welfare and certification by the WHO Regional Office.

Implementation barriers

- Insufficient financial and human resources
- Difficulty in coordinating collaboration among a large number of Government ministries

Implementation enablers

- Clear policy guidance for implementation
- Stakeholders' commitment, political will and structures in implementation enable community participation
- Non-monetary teacher incentives for involvement in implementation of the strategy

Impact of school health policies

- Over 20 years of progressive implementation of the HSS
- Evaluation of the strategy found improvements in nutrition at school, greater student retention, greater engagement in learning, less school violence, more job opportunities and strengthened community agriculture.

Sustainability of school health policies

- The HSS has been implemented progressively over the past 20 years. It is well known in Paraguay, where it is "owned" by the community.
- Intersectoral collaboration supports sustainability; however, effective communication and coordination could enhance the sustainability of the collaboration, particularly when it is implemented at greater scale.

Philippines

The Philippines is a large archipelago nation in the Western Pacific with a population of over 109 million, 30.6 million of whom (27.9%) are of school age (5-18 years). All aspects of elementary, secondary and informal education in the Philippines are overseen from a central office in Manila by the Department of Education and from local field offices *(38)*. Education is currently compulsory to grade 12, an increase over 2013, when the length of compulsory education was raised from 10 to 12 years. In 2019, 97% of school-aged children completed their education from kindergarten to grade 6, and 77% of these completed their education through to grade 12 *(39)*. The languages of instruction are English and Filipino, the two official languages; other local languages are used in elementary schooling *(38)*.

How is "school health" defined and conceptualized in the Philippines?

The concept of HPS is the basis for most school health programmes in the Philippines.

"Though we do not have a direct policy on HPS as how WHO states it, most of our school health programmes actually integrate the concepts of HPS. HPS has been a framework provided for by DOH for the last few years. In the Philippines, this programme was not implemented as is, instead, the key components of the HPS were made as core key result areas in almost all the programmes being undertaken by the school health. We do not name it as HPS, but we embody its recommendations in all of our new and old programmes. In a sense, we have implemented HPS just not using its official programme name."

"We don't have a programme that we call 'health promoting school'; we do a school health and nutrition programme, so it's a complementary programme that covers a lot of interventions, but I think the school health and nutrition programme is primarily based on health promoting schools. The thing is we don't call it a health promoting schools programme, we call it school health and nutrition."

The Department of Education launched a flagship "health in schools" programme, *Oplan Kalusugan (OK) sa DepEd*, on 16 July 2018. The objectives of the partnership programme include:

- provision of basic primary health, nutrition and dental care;
- education in healthy lifestyle behaviour for school staff and students; and
- links between health service providers and local governments for child and adolescent health services *(40)*.

The OK programme indicates, and the perspectives of the key informant illustrate, that the objective is to inform a school health policy (including the school health and nutrition programme) in the Philippines and that it is used as a guiding conceptual framework. **"So, while we appreciate the health promoting schools, it's sort of used as a framework …."**

What are the organization and infrastructure of the OK programme and school health policies in the Philippines?

Implementation of the education policy is relatively centralized, led by the Department of Education, and education policies are implemented directly in schools. Conversely, when the Department of Health develops a policy, implementation is usually coordinated with the local government and other stakeholders, depending on the nature of the policy. The school health and nutrition programme, which has been operating for more than 20 years, includes a large number of interventions, including the provision of:

- school health services;
- WASH;
- school nutrition;
- sexual and reproductive health education;
- inclusive education; and
- health education to support a healthy lifestyle.

Health education also depends on the health needs in the many islands of the Philippines. Most of the interventions that are part of school health and nutrition are delivered in all regions, but those to prevent infectious diseases and certain lifestyle behaviours are provided according to the needs of local communities. **"... if they say have very high incidence of malaria, or worms, then they [school staff] will put priority on this."**

Who is involved in the school health and nutrition programme?

Many organizations and Government departments are involved in implementation of the school health and nutrition programme in the Philippines.

National government

The Department of Education leads implementation of the school health and nutrition programme and provides the majority of funding for the programme, with funding for the provision of education (e.g. salaries of school staff). Funding may come from another Government department for a programme to meet a specific health need, usually the Department of Health. The Bureau of Learner Support Services of the Department of Education is responsible for coordinating the school health and nutrition programme.

"...for a programme on tobacco control...where a certain NGO or organization will be a key partner stakeholder, they may select a certain school where they will pilot a certain intervention or a school improvement programme ... [this] would indicate sharing of resources in a partnership. Generally, though, most health and nutrition programmes are funded by Government funds either from the Department of Education or the Department of Health and its other implementing units, the local government units."

In collaborations between the departments of Health and Education, that of Education leads and implements school health interventions that affect learning outcomes. For example, the Department of Education leads and implements basic screening services (e.g. hearing, vision), whereas the Department of Health funds and distributes medicines used by schools, such as vaccine doses.

The Department of Social Welfare may also be involved in the school health and nutrition programme, providing support for early child care centres and interventions for out-of-school youth and other hard-to-reach child populations.

Local government

The local governments in regions and districts in the islands of the Philippines are responsible for allocating and distributing funding to schools. Additional funding for school improvement and some school health interventions are also provided by local governments. School officials and superintendents in school division offices support school operations. Well-performing division heads ensure that school health and nutrition programme and projects are integrated into school improvement plans, with the necessary administrative and financial support, and aligned with the principles of school-based management.

Development partners

A number of development partners support implementation of school health interventions in the Philippines. These include UNICEF, Save the Children, UNESCO, the Southeast Asian Ministers of Education Organization, WFP and UNFPA. Partners tend to provide broad support for development of school health policy, more targeted support and, at times, funding for international programmes such as WASH in schools and school feeding programmes.

Schools and local communities

In the school management infrastructure in the Philippines, school leaders and partners (industry, small businesses, parents and caregivers) develop school policies and manage the school environment. Schools also have governing boards; however, the distribution of leadership differs from school to school.

"Sometimes the school governing board, it's only the schools division superintendents or school principal that makes decisions, we are actually doing a lot of capacity building and leadership training to schools division superintendents and school principals on local planning with appropriate representation of key stakeholders to ensure there is local ownership and it is contextualized based on identified local needs. It is hoped that the UNICEF and SEAMEO [Southeast Asia Ministers of Education Organization] calls for school-based management (a lot of capacity building has been done on this advocacy in the past decade) gets to be realized and implemented at best effort. Circumstances are never perfect, but school-based management trained school heads and supervisors somehow can maximize resources to meet local education needs in the school settings."

Barriers to implementing the school health and nutrition programme

A number of barriers were reported to implementation of the school health and nutrition programme in the Philippines. Most of the barriers are associated with resources, both monetary and personnel. For example, the key informant reported that the current ratio of school health nurse to students is 1:4000 to 1:6000.

"Many of our good school health nurses, if given a chance to go abroad for their profession, [would] readily take up the challenge. Due to current high demand of Filipino nurses in Europe, Canada and the Middle East, there is a high turnover of our capacitated [qualified] nurses. The most common reason provided are non-competitive compensation and limited opportunities for career progression."

Lack of resources for school infrastructure is another barrier, particularly in more remote areas of the Philippines, where schools tend to have inadequate health and sanitation facilities for students. Schools in remote areas not only lack resources but are also less likely to implement school health programmes, with limited awareness of the school health and nutrition programme and related policies in local communities. The situation is exacerbated by controversies such as that about "Dengvaxia", a dengue fever vaccine that was delivered by the Ministry of Health in schools in the Philippines, which appeared to place previously uninfected people at higher risk of severe dengue fever.

Lack of useful teaching resources that can be integrated easily into lesson planning, delivery and monitoring is another barrier for teachers implementing the school and health nutrition programme.

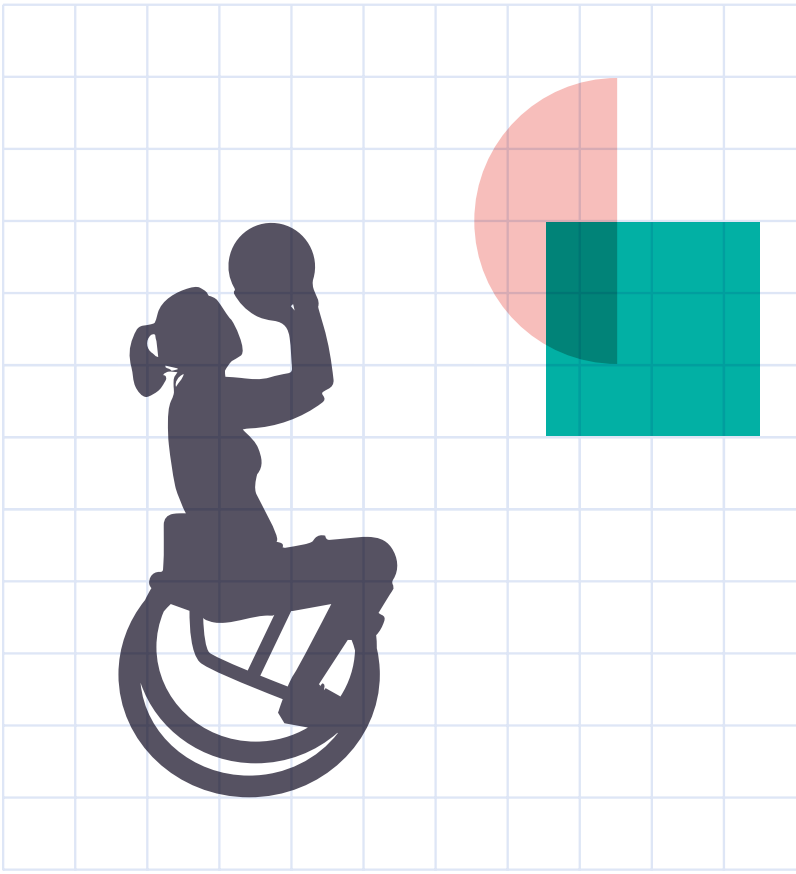
There is limited monitoring of bullying in schools, physically or on social media, and lack of a standardized reporting system, which could be used to inform school health promotion activities for the prevention of violence.

Enablers to implementing the school health and nutrition programme

A number of enablers were identified that could support implementation of the school health and nutrition programme. The presence and support of active nongovernmental organizations and development partners were reported to enable the programme, including international and WHO region-specific policy guidance for HPS and school-based resources such as the Focusing Resources on Effective School Health (FRESH) website and toolkit (https://www.fresh-partners.org).

The presence of school health personnel, primary health centres in every village and established referral systems for students to access health care support mass deworming and some vaccine programmes and add value by encouraging closer relationships and collaboration between health professionals and school staff. **"The health services [in local communities] now have staff recognized as an ally among teachers ...."**

School management infrastructure, including school governing boards and parent–teacher associations, ensures the involvement of the local community in decisions about school operations. While the degree of involvement depends on each school principal, the infrastructure supports their involvement and allows the school to identify and quickly respond to local health and education needs.



Monitoring and evaluation of the school health and nutrition programme

Implementation of the school health and nutrition programme is monitored by the Department of Education, while the health needs of the population are monitored by local health providers and managed by the Department of Health. School health promotion that is not associated with school health services is monitored by school managers and others members of the administration according to school management principles.

Monitoring indicators are provided by the departments of Education and Health. The indicators are either derived from international standards and guidelines or are developed by the Department of Education in consultation with development partners, the latter also tending to be informed by international standards for sanitation, health and nutrition (e.g. WASH). **"We are doing a massive online course for the [school] managers [that is supported] with monitoring …."**

The key informant said that better understanding is needed of which areas of cognition and learning development are influenced by the school health and nutrition programme.

The Department of Health conducted a global school-based student health survey in 2015, with questions relevant to the national curriculum and focus in Filipino and English. The modules covered behaviour and protective factors, including alcohol consumption, body mass index and dietary patterns, consumption of drugs, hygiene, mental health and physical activity.

Impact of the school health and nutrition programme

WASH in schools programme was highly successful during the period of implementation.

"We are very proud of our WASH in schools programme. I think for WASH in schools we are leading, more or less, Asia and other countries. We have a very good WASH in schools programme, it's very useful with the influx of the pandemic. So, we are able to use that of course when the schools start to open."

There is also evidence of much stronger relationships and collaboration among health professionals and school staff, and some school health staff, especially school nurses, support health education.

While most schools are implementing some of the programmes (e.g. school feeding), some newer programmes (e.g. mental health) are being implemented less widely, perhaps because of prioritization of interventions according to local needs or due to lack of awareness of the newer aspects of the school health and nutrition programme. **"… there's only a few schools that are implementing all programmes."**

Sustainability of the school health and nutrition programme

The key informant noted improvements in health promotion in schools in the Philippines during the past decade. The perspective of teachers was seen to have evolved, such that ensuring that schools support the health of students was now perceived to be of value. **"I'm very happy that they're [teachers] aware of the importance of making sure that schools [are] a healthy environment."**

While the role of health in education and more broadly the role of educators may have evolved, health promotion is still often referred to by teachers as "additional work". Thus, the key informant suggested that teachers' perspectives should be broadened and a move made towards a whole-school approach to health promotion in schools in the Philippines.

Table 5. Summary for the Philippines

Key features of school health organization

- School health promotion is delivered as part of the school health and nutrition programme and other school health policies, such as the OK sa DepEd partnership. The programme is led by the Department of Education in collaboration with the Department of Health for the delivery of certain health interventions.
- The school health and nutrition programme includes health education (including sexual and reproductive health), access to basic health services, WASH and school nutrition.
- Implementation of the programme is funded by the Department of Education through school division offices to school managers and principals, who are responsible for managing the budgets of their schools.

Implementation barriers

- The availability and retention of school health personnel are limited, and the results are limited because school health personnel serve large numbers of students.
- Schools in remote areas have limited resources and poor or inadequate infrastructure for physical activity, and some have limited access to safe drinking-water.
- Teaching resources for embedding health promotion in lessons are limited.
- There is no monitoring system and limited reporting of school bullying and violence.

Implementation enablers

- Active support by nongovernmental organizations and existing policy guidance, manuals and toolkits to support school health promotion.
- Every village has a primary health centre.
- School-based management infrastructure ensures the autonomy of school principals to determine and allocate resources appropriate to their needs and contexts.

Impact of school health policies

- The WASH in schools programme is well established and successful. It has been particularly helpful in responding to the COVID-19 pandemic.
- Stronger relationships and collaboration among health professionals and school staff have developed over the past decade.
- More research should be conducted to measure the impact of education associated with school health promotion.

Sustainability of school health policies

- There is shared recognition throughout the Philippines that schools should provide a healthy environment for staff and students.
- Many teachers still consider that health promotion is “extra work”, as they have little time and little access to other resources.

Senegal

Senegal is a country in West Africa with a population of 16.8 million, of whom 5.8 million (34%) are of school age (5–18 years) *(41)*. Education in Senegal is free and compulsory up to the age of 16 years, although compulsory schooling is not strictly enforced. The formal education system comprises 6 years of primary school, 4 years of junior secondary school and 3 years of senior secondary school. According to the Programme for International Student Assessment, the rate of transition from primary to junior secondary school increased from 33% in 2006 to 53% in 2011 *(42)*. The languages of instruction in Senegal are those of the local communities. French tends to be the language of instruction in public primary schools; however, the six indigenous languages (Wolof, Malinka, Pulaar, Jola, Sereer and Soninke) are encouraged as languages of instruction *(43)*. More than 20 additional languages are spoken in the country.

How are health-promoting schools defined and conceptualized in Senegal?

The term "school health" is used, rather than HPS, to describe current health promotion in schools in Senegal. School health is considered critical for education and for the country overall, given the prevalence of health issues among school-aged children and adolescents. **"… [adolescent sexual and reproductive health is] a major issue in our country, with early pregnancies and marriages."**

The role of schools in promoting health in Senegal is considered significant, reflected in the fact that school health is the responsibility of a specific division of the Ministry of Education, of which the director reports directly to the Minister. School health services were created by the General Inspectorate of Health and Medical Services in West Africa and, in Togo, by the Governor General of French West Africa by a Ministerial Order in 1942. After independence, Senegal was strongly influenced by the French system, which attached school health to the Ministry of National Education. Thus, the transfer of responsibility to the Ministry of Education was considered a major political reform.

What are the organization and infrastructure of school health in Senegal?

School health in Senegal comprises education on sexual and reproductive health, infectious diseases, risk behaviour and noncommunicable diseases, WASH and nutrition. Activities in these five areas are considered distinct but related, but there is no whole-school approach to promoting health (e.g. HPS). Resources for the five activities are provided by the Ministry of Education.

Schools are not obliged to conduct health promotion activities, except those listed in the national policy and curriculum. They thus have flexibility and autonomy in deciding which health promotion activities to implement. The choice may also be influenced by organizations in the local community.

Who is involved in school health?

National and local government

Responsibility for school health in Senegal rests with the Ministry of Education. Within the Ministry, the School Medical Control Division manages all aspects of school health activities and allocates the necessary resources. Several sub-offices in the division address specific school health activities:

- health education and curriculum development;
- adolescent sexual and reproductive health;
- nutrition education and supplementation;
- communicable diseases (malaria, HIV/AIDS, tuberculosis, neglected tropical diseases);
- noncommunicable diseases;
- addiction prevention; and
- WASH and environment.

The Ministry of Health provides technical expertise and supports the work of the School Medical Control Division and the Ministry of Education. This collaboration is based on a memorandum of understanding, signed in 2000, that lists the roles of and relations between the ministries. **"In 2000, both ministries signed an MoU [memorandum of understanding] to define the content of their relationship. [The] Ministry of Health brings the technical expertise."** The Ministry of Health is also responsible for allocation of health professionals to work in schools or in health services.

Development partners

Several development partners are involved in providing programmatic support to schools and local communities within programmes that they fund. The key informant mentioned that UNICEF is involved in delivering a vaccination support programme, and other development partners are involved in WASH activities, reproductive health and supporting health literacy.

Schools and local communities

As noted above, schools play a significant role in implementing health promotion activities. Schools commonly involve parents and caregivers in this and other school operations. The involvement of parents is often greater in rural schools, where limited resources affect education. For instance, in one rural community, parents and caregivers specifically raised produce to feed students and staff at schools.

"Often, parents do not have many resources to contribute, but a great willingness to contribute to the well-functioning of the school".

"… in all our activities, at the start we do a bit of advocacy at the level of parents' associations."

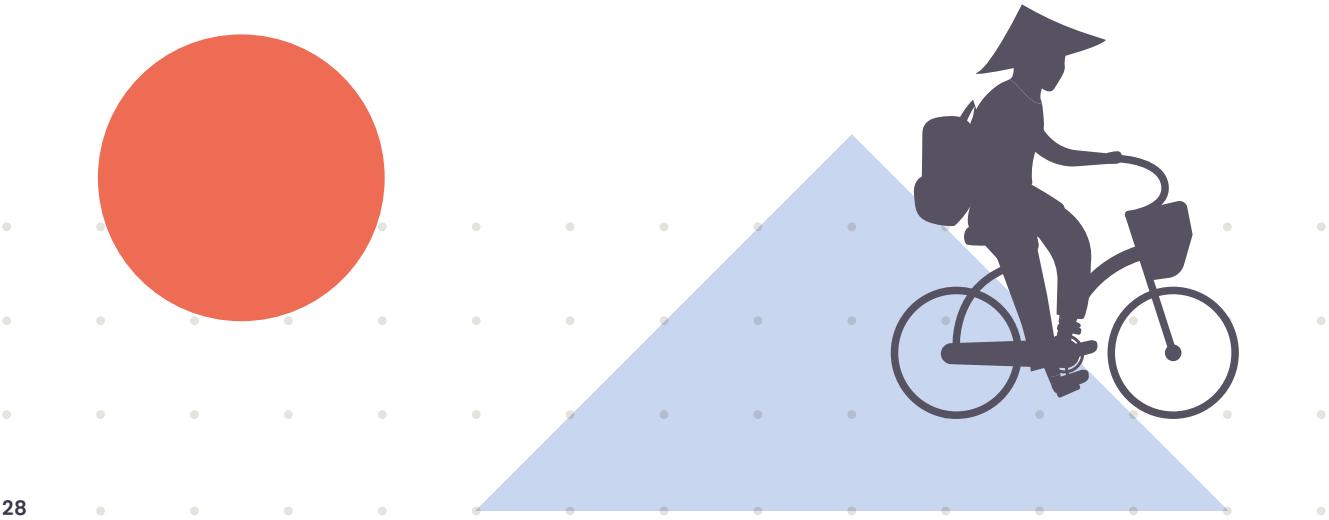
Students are also actively involved in the management of health promotion activities. While student "clubs" have always existed, schools are now building "school governments", a type of student association that participates in school governance and management.

Monitoring and evaluation of school health policies

All school health activities are monitored and evaluated by the Ministry of Education. In each region, the Ministry has a focal point who is responsible for health and the health priorities of the region. School inspectors visit schools and collect information for specific monitoring indicators. Even if school health activities have not been conducted, the inspectors still collect and report data. In 2019, the ministries of Health and of Education started using digital platforms to collect data and tested the system in a nutrition programme in which teachers were directly responsible for entering data.

The relevance of the indicators for health promotion is, however, limited, as data on teaching and learning outcomes tend to be prioritized.

"We would be interested, for example, in indicators such as the number of schools that have toilets, the number of schools that have a water source, the number of children living with HIV… these indicators are not tracked".



Barriers to implementing school health activities

A variety of barriers to implementing school health activities that hinder progress towards a whole-school approach to promoting health were reported by the key informant. Lack of sufficient resources significantly affects school health activities due to limited availability of health personnel for health promotion in schools. The School Medical Control Division has only a small budget for operating expenses and therefore cannot appropriately finance school health activities.

The lack of a mandatory national policy for school health promotion means that school health activities cannot move beyond a programmatic focus, limiting the possibilities for collaboration.

"… until now there is no forum for discussion and in-country coordination, despite the multiple efforts of the Ministry of School Health Division in the Ministry of Education. There are consultation spaces at programme level, but this is also a challenge."

Differences according to type of school or wider contextual factors are also barriers to school health promotion in all schools in Senegal. Schools in rural communities differ from those in urban areas, as they have fewer resources and rely on contributions of time and resources from the local community, especially parents and caregivers. **"In schools where, for example, the president of the parents' association has a health background, we can see a great investment in health promotion activities."**

School resources are also influenced by the type of school. In Senegal, primary school education is free, whereas enrolment in secondary schools requires a financial contribution from parents. The resources of secondary schools may therefore be particularly limited in poorer communities.

Enablers for implementing school health activities

Certain enabling factors for school health activities were described, partly as strategies to overcome some of the barriers cited above.

Training of teachers in school health was seen as a means for embedding health promotion into the education of students and for countering the limited availability of health professionals.

"In the absence of the necessary medical staff, the effort of training and providing material to teaching staff, although it does not replace this, fills an important gap, and it also contributes to the sustainability of interventions."

Financial support from local authorities is considered another enabler for implementation of health promotion activities in schools. Support for health promotion from students, parents and caregivers was seen to increase the likelihood that health promotion in schools would become a strategic priority and would support the sustainability of health promotion activities.

"[Parents] … have a listening power, they intervene in schools and often they are involved in school management committees and, as such, influence the decisions made in terms of prioritization of activities."

Impact of school health activities

Collection of data for certain indicators of health promotion in schools was considered to require improvement; however, it was reported that the impact of any school health activity is difficult to assess in the absence of programmes that are financed and stable in the medium and long term.

Sustainability of school health activities

The key informant noted that planning is essential. In particular, a 5-year national school health promotion strategy would be crucial to adoption of a whole-school approach to promoting health and highly beneficial for the sustainability of school health in Senegal. A national strategy of school health promotion would attract dedicated funding and help define priorities, milestones and objectives for the midterm.

At local level, continued professional education of school staff, particularly principals and teachers, was considered an important strategy that would also contribute to the sustainability of health promotion and the extent to which it can continue when resources are limited or intermittent. Opportunities might be opened by widening the understanding of development partners on how vertical programmes might fit within a whole-school approach and how they might be funded accordingly. **"[Funding for school health promotion] depends on timely opportunities, for either local actors or development partners."**

Table 6. Summary for Senegal

Key features of school health organization

- School health promotion is delivered in all schools in Senegal, led by the Division of School Medical Control in the Ministry of Education. The Ministry of Health provides technical expertise and health professionals for school-based or school-linked health services.
- School health promotion is not mandatory; some schools embed health promotion throughout educational activities.

Implementation barriers

- Insufficient financial resources
- Lack of a national school health promotion strategy
- Differences between rural and urban schools in resources and local community engagement

Implementation enablers

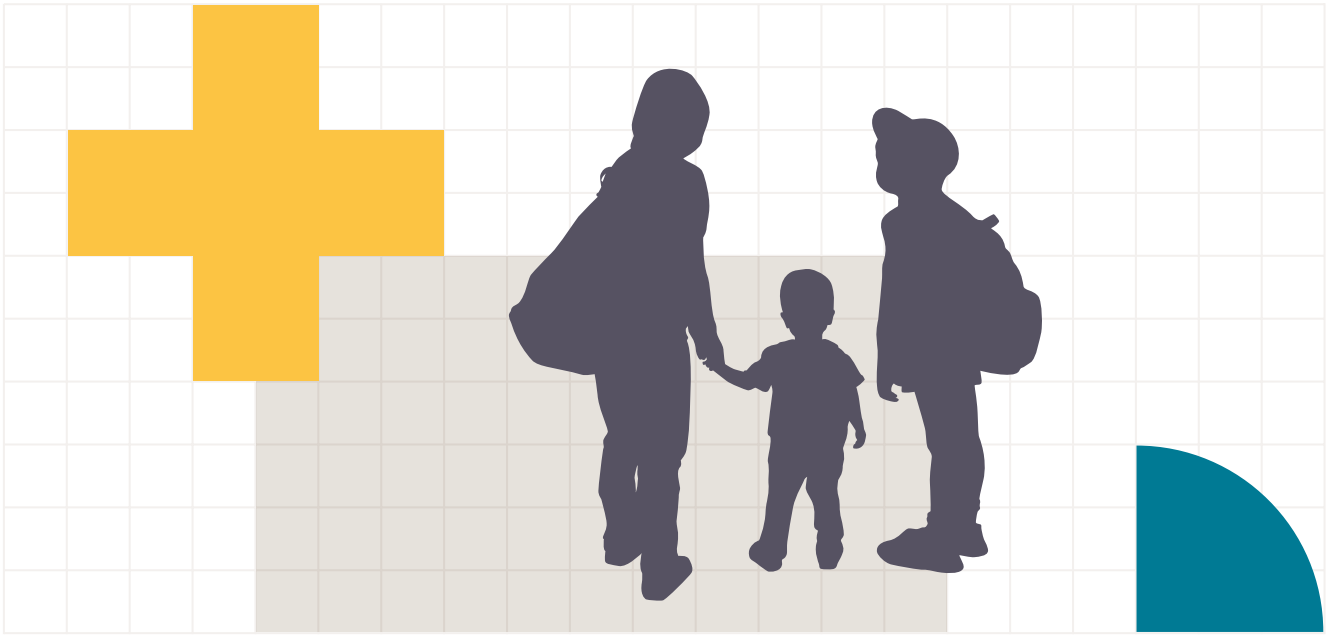
- Training of teachers and school leaders in health promotion
- Financial support from local government
- Involvement of students and parents in school governance (through associations) increases opportunities to influence health promotion.
- Greater appreciation of whole-school approaches by development partners

Impact of school health policies

- Assessment of the impact of health promotion in schools is difficult because monitoring indicators are not directly linked to school health activities or health outcomes.

Sustainability of school health policies

- A 5-year strategy would significantly increase the sustainability of school health promotion.
- Teachers and school leaders should be trained in health promotion.
- Substantial funding is necessary for school health from the State and/or partners.



South Africa

South Africa is a country on the southern tip of Africa with a population of 59.5 million, of whom 15.1 million (25.4%) are of school age (5–18 years) *(44)*. Education in South Africa lasts for 13 years, with elementary education for 7 years and secondary education for 6, comprising 3 years of lower- and 3 years of upper-secondary education. Education up to lower-secondary level is compulsory. Students in upper-secondary education are streamed into two tracks, academic (general) or technical. According to 2018 Government statistics, participation in compulsory schooling was "virtually universal" (97.4%) *(45)*. In 2018, 74.5% of students were still in school by the age of 18 *(45)*. Eleven official languages are spoken in South Africa, including Zulu, Xhosa and English. Teaching in schools is usually in the community's native tongue during the first 3 years of schooling, with a switch to English in grade 3.

How is "school health" defined and conceptualized in South Africa?

The integrated school health programme includes screening for oral health, vision, hearing, speech, nutritional assessment, physical condition, mental health, tuberculosis, chronic illness and psycho-social condition. The programme includes health screening in four grades during schooling:

"We focus especially on four grades of the 12 million children; we focus especially on grade 1 and then also grade 4 and grade 7, and then grade 10. So, the idea is to catch [pupils] in grade 1 to start off and identify possible challenges that the child might have then. Grade 4 is pre-puberty so the focus there is on education but also on vaccination, and then Grade 7 is now where they start to be sexually active and we provide them with more health education and information … [in] grades 1, 4, 7 and 9 we [also] have health screening."

Sexual and reproductive health services and education are also components of the integrated health programme. In view of the high prevalence of teenage pregnancy, which results in a high proportion of female students leaving school early, the programme also supports the return of young mothers to school and child care. **"[in previous years] … there were 118 000 girls under 18 delivering babies. So those girls usually or mostly drop out and then the cycle of poverty is just continuing …."**

The value of supporting students' health so they can participate in and reap the benefits of good-quality education is reflected in the support for the integrated school health programme. **"We are really thinking that health of children is paramount for development, for reaching the goal of education for all or quality education for all, so it plays a pivotal role."**

The integrated school health programme in South Africa does not, however, use a whole-school approach to promoting health, such as embedding health promotion into the school curriculum. This was perceived as reflecting the focus on priority health needs and not a view that whole-school approaches are unimportant.

What are the organization and infrastructure of the integrated school health programme in South Africa?

The integrated school health programme is implemented in all schools in South Africa. It includes the provision of essential, comprehensive primary health care services and also health screening at particular development stages for early detection of health conditions that could affect learning (e.g. hearing and vision).

As the integrated school health programme is provided to schools, it is not necessarily mandatory, and consent is required from parents and caregivers for students to receive health services.

The resources distributed to schools comprise human resources and the necessary infrastructure, facilitated by a national body for Health, Education and Social Development based in the Ministry of Education, and by offices in each of the nine provinces. Funding is provided for:

- a team that supports students who are experiencing difficulty in learning, coordinates access to a school nurse and refers students to other health services when necessary;
- nurses allocated to schools, as not all schools have their own nurse, and some work in several schools; and
- delivery of health services in primary and secondary schools.

Who is involved in the integrated school health programme?

Many organizations and agencies are involved in implementation of the integrated school health programme in South Africa.

National Government

The Ministry of Education developed and leads the integrated school health programme. A dedicated school health programme department within the Ministry manages the programme, allocates resources and facilitates collaboration with other Government departments and with development partners.

Local government

Each of the nine provinces has an office for the integrated school health programme that allocates funds, implements the health programme and coordinates with the national Government and development partners in providing regional support for school health.

Development partners

WHO is currently reviewing the integrated school health policy and has also provided support and feedback on the initial policy. UNICEF also provides support and, with WHO, meets every quarter with the school health programme department in the Ministry of Education.

"We also have a quarterly meeting where we involve partners like UNICEF and WHO so they can provide us with feedback on programmes that they have and we can also provide them with an update of what we are reaching."

The Africa Centres for Disease Control and Prevention (CDC) provide support for monitoring health indicators, particularly in the surveillance of infectious diseases, to ensure that prevalence estimates are up to date and can be used in implementing the school health programme.

Schools and local communities

The school support teams deliver the integrated school health programme and are responsible for facilitating access of students to school health services, with the consent of parents and caregivers.

"… the health person will be part of the school health base support team to contact the [school] nurse or agree on a time for the nurse to come to the school or agree on referrals to supporting the referring process."

They also coordinate and, when appropriate, refer students to health professionals and work with parents and caregivers if students need support.

Barriers to implementing the integrated school health programme

The barriers to implementing the integrated school health programme in South Africa include lack of resources for the programme and geographical and demographic characteristics that influence student health and education and teacher expertise.

Lack of resources was reported as a significant barrier. The shortage of school nurses can impede access, and discrepancies in access may arise, for instance, when children screened for vision difficulties and referred onwards are unable to access further health care.

"But there are serious problems … children are screened, and they are referred, and a high percentage of the children referred are not receiving what they should receive, for instance glasses or hearing aids or dental support."

Poor communication and lack of a clear distribution of responsibilities between the national department, provincial departments, district staff and development partners involved in implementing the school health programme are further barriers. **"I also think the integrated national, provincial and district levels is not optimally developed, or they are not optimally collaborating …."**

Teachers who deliver the health education curriculum, particularly comprehensive sexuality education, may be reluctant to provide important health information to their students.

"… teachers are struggling to bring across the message of sexual education and they struggle to talk about penis and vagina. We have developed scripted lesson plans for the teachers to make it easy."

Major differences among the nine provinces and the districts in the provinces in the needs of students living in very rural and remote areas and those living in more urban areas present a significant challenge to implementation of the school health programme; **"… the children are in deep rural areas and there is severe poverty in some areas."** These differences also influence the nature of parent engagement and the education required for them to give informed consent for their child to access health services. The key informant suggested that much more awareness-raising is required in some areas and communities and commented that, during the COVID-19 pandemic, much of the advocacy to parents and caregivers about access of children to primary health care has been stopped.

"In SA, we don't provide a health service to the child if the parents didn't give consent and especially when we get to vaccination for instance or when the child needs to be de-wormed so the parents provide consent … but what happens in SA is that the child is with the grandparents in a rural area and the mum or dad or mostly the mum is working in a fruit farm somewhere so to get consent is frustrating because there is a percentage of parents who don't consent…. Some parents don't collaborate or they would but can't or they don't collaborate because they don't feel it is right."

Enablers to implementing the integrated school health programme

Political support for the programme and the role of the Ministry of Education in leading development and implementation of the policy is a clear enabler and has contributed to the idea that promoting health in schools is an important aspect of education.

"One thing that I think it has achieved is the political buy-in and also that is the one thing … the fact that education is not a silent partner in this, education is taking a leading role in this whole programme so I think that is two of the major successes."

Another reported enabler is community engagement in implementation, which leads to a sense of ownership of the programme in local communities. The key informant said that this is reinforced when it is evident that the health of students is improving. **"… within education there is a huge support for this and we know that children are benefitting …."**

Monitoring and evaluating the integrated school health programme

The Ministry of Education is monitoring implementation of the integrated school health programme, primarily through health indicators and associated targets, and the reports include one to Parliament. The Africa CDC provides support in surveillance of specific diseases for the purposes of programme planning. **"… CDC in health is supposed to evaluate the impact [of delivery of treatment for deworming] so they [did] a baseline of the prevalence of the worms across the country …."**

Impact of the integrated school health programme

It was evident that a more integrated school health programme was necessary in Africa. The key informant reported that there is considerable support for the programme and for the importance of promoting health in schools. **"… to us it is just a no-brainer we know that it is going to help children."** The key informant also explained, however, that management of certain infectious diseases is necessary for the full impact of the integrated school health programme to be realized.

"For instance, helminthiasis is right across [South Africa], but in some areas there is a high prevalence according to WHO standards … you know this poor child is getting food from the school and perhaps not at home sufficiently and the worms take a toll."

Sustainability of the integrated school health programme

Two elements were reported as critical for the sustainability of the integrated school health programme. The first was continued, sustained political support and collaboration throughout the Government. The key informant indicated that this was expected to continue.

"I don't think there is a chance that this programme can fall through the cracks due to the political interest and the political support. I doubt … even though the fact that we don't collaborate optimally, we [still] meet diligently every month. In my own opinion this is going to stay."

More advocacy and education of school staff, parents, caregivers and the local community were reported as essential for the sustainability of the integrated school health programme.

"… we do get good support from parents but I think support will be much better if they know the services will be provided."

"… we need to up the advocacy for secondary schools on sexual reproductive health services."

Table 7. Summary for South Africa

Key features of school health organization

- School health promotion is delivered through the integrated school health programme to schools in all nine provinces of South Africa.
- Implementation of the programme is led by a dedicated department in the Ministry of Education in collaboration with other departments and with support from development partners (WHO and UNICEF).

Implementation barriers

- Insufficient financial and human resources
- Significant differences in the needs of students and communities in remote and rural areas and in more urban areas
- Difficulty in obtaining parent and caregiver consent for health care, in some cases because of work

Implementation enablers

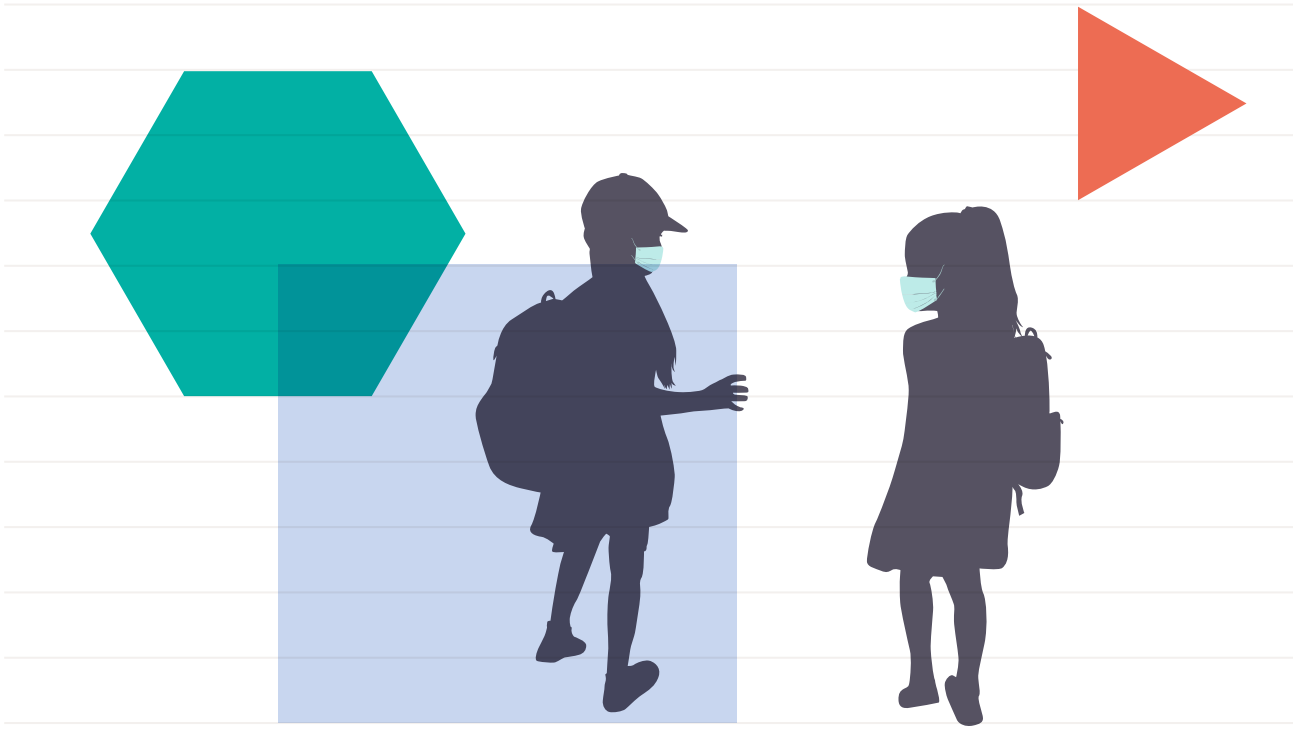
- Political support for the programme and leadership of the programme by the Ministry of Education

Impact of school health policies

- Widespread support and understanding of the value of the programme in improving the health of students and local communities

Sustainability of school health policies

- Continued political support and effective collaboration among Government departments and with development partners
- Increased advocacy and education of school staff (particularly for sexuality education in secondary schools) and parents and caregivers.



Tunisia

Tunisia is a North African country with a population of over 11 million, of whom 2 million (18%) are of school age *(46)*. The country's education system was initially based on the French system; since independence in 1956, however, schools have placed greater emphasis on the Arabic language and culture, and Tunisia's official language is Arabic. Recently, English has been included in primary to higher education programmes. Primary and secondary education in Tunisia lasts for 13 years, the first 9 of which (*enseignement de base*) are compulsory *(47)*. Since independence, Tunisia's investment in education has increased the literacy rate; in 2014, the literacy rate of 15–24-year olds was 96.1%, while that of people over 65 was 39.8% *(48)*.

How is "health-promoting schools" defined and conceptualized in Tunisia?

HPS has not been implemented in Tunisia; however, a free school health programme has been in place since 1981, which delivers school health services with basic health care. **"The concept of HPS as defined by WHO–UNESCO is very pertinent but idealistic. [It is] a reference concept in our research and work."**

Health promotion in educational establishments has increased recently, with the support of the Directorate of School and University Medicine in the Ministry of Health and the Higher Institute of Education and Continuing Training in the Ministry of Higher Education.

"... in 2018, for the first time in Tunisia, we organized in the WHO offices a debate between all partners involved in health education in Tunisia to reflect together about possible plans for health promotion in young Tunisians, because we have understood that it is ... a collaborative responsibility."

Increased awareness about the relevance of health promotion among young people in school is considered to be due to greater involvement and training of health and education specialists.

"with the evolution in the way of thinking of doctors, more research and the evolution of teachers' training, who have had 'health education' as a subject in their training since 2004, the mentality is slowly changing."

In 2019, the Directorate of School and University Medicine at the Ministry of Health initiated a pilot *"école promotrice de santé"* (health-promoting school) in southern Tunisia to create a pool of experts in school health promotion for scaling up implementation of the approach. The programme will focus on practical implementation of HPS, with sessions on existing structures, the history of school health and the applicability of HPS to local contexts. One key informant reported that the director of this technical service has recommended that implementation of the HPS approach be **"... participative, multisectoral, a genuine partnership between the school, the family and the community ... with the specificities of each school to be taken into consideration".**

What are the organization and infrastructure of school health in Tunisia?

The school health programme is relatively structured and is mandatory for public and private schools. Three levels are involved in this programme: national (Ministry of Health, Directorate of School and University Medicine), regional (regional health directorate, school health service) and local (schools), each level having distinct roles and responsibilities in implementing the programme. For instance, at regional level, there is a doctor, a head of department and a regional coordinating supervisor of school and university health, while in schools, there is a school health team (doctor and nurse). The programme mainly delivers school-based or school-linked health services, such as vaccination; however, one key informant noted that **"Health services provided at schools have an essentially preventive focus (outside oral health). Health services outside school have a curative focus."**

Broader health promotion currently tends to be led by individual schools, with some activities supported by school policies (e.g. not permitting fast food to be available or offered in schools). Such initiatives are usually led by school principals and may also be strongly advocated by parents and caregivers.

Who is involved in school health?

Government ministries

Several ministries have a role in implementing the school health programme in Tunisia. The Ministry of Health Directorate of School and University Medicine is responsible for the design, implementation and evaluation of the programme and for the health outcomes of Tunisian schoolchildren and adolescents (3–18 years). The Ministry of Higher Education is responsible for coordinating with the Ministry of Health in implementing the programme in universities, including research in health education and training of medical students and pre-service teachers. The Ministry of Education coordinates with these two ministries for implementation of the programme in schools. Specifically, the Directorate-General for Primary Education and the Directorate-General for Preparatory[2] and Secondary Schools are involved, with the University works office[3].

Other ministries may be involved, depending on the type of school health support. For instance, the Ministry of Women coordinates with the Ministry of Health on all interventions in early learning centres.

Development partners

Several partners provide technical, programmatic and financial support for the school health programme. For instance, the Ministry of Health submits a school health activity plan and budget annually to WHO, indicating priorities for financial support; UNESCO supports research projects in collaboration with the Ministry of Education; UNICEF supports continued education with adolescents who leave school early; and UNFPA supports initiatives in sexual and reproductive health education.

Local schools and communities

School principals, teachers and staff develop and implement school policies aligned with the school health programme. Health clubs are organized jointly by a teacher and the school doctor for students interested in joining. In some schools, parent associations actively support school operations and implementation of the school health programme. Students have opportunities to volunteer through student clubs, which organize cultural and artistic health thematic events, generally led by teachers of life and earth sciences.

Monitoring and evaluation of school health

As the school health programme in Tunisia is focused predominantly on health services, indicators of services are monitored and evaluated, including the proportion of children enrolled at school who have been vaccinated. Monitoring and evaluation are conducted by the Ministry of Health Directorate of School and University Medicine. According to one key informant, timely access to data is difficult.

"[There is] difficulty in annual reporting on time due to the delay in the delivery of regional reports (paper version) and data entry. The school year is 9 months, and processing and analysis of data require approximately 6 months, which generally falls during the next school year."

No information was available on whether school policies such as the availability of nutritious food are monitored and evaluated.

Barriers to implementing the school health programme

Several barriers were reported by the key informants to progression from the current school health programme towards a broader, whole-school approach to health promotion that is more consistent with HPS. The socioeconomic and political context of education in Tunisia tends to distinguish learning from health, the former being the priority in schools. **"In Tunisia, we have a model which is very neoliberal, where competition among students is high and where the priority for parents and students it to have good marks; the rest is secondary."**

Reservations about discussing sensitive health topics such as sexual and reproductive health are a barrier to high-quality sexuality education and to accessing relevant health services.

The Government has a centralized, bureaucratic tradition, with a hierarchical administration. Political instability has resulted in a high turnover of ministers for both education and health, which has halted progress towards a broader approach to health promotion, for instance by delaying decisions. **"… suddenly there is a change of minister or team, and we are obliged to start from the beginning."** The lack of adequate human resources is also a result of the socioeconomic and political transition in Tunisia.

[2] The preparatory course is an integral part of basic education but is not compulsory. It is provided by the Ministry of Education in public, private and quasi-public schools.

[3] Public institution in the Ministry of Higher Education responsible for scholarships, university loans, social assistance, student accommodation, university catering, promotion of culture and sports and psychological and medical support for students.

There is no dedicated budget for health promotion, and financial resources are limited to specific health initiatives such as immunization and school health services, drawn from State budget development partners.

Collaboration among sectors may be difficult, exacerbated by a language barrier: the language of most health professionals is French, as doctors often complete their medical education in French, while the professional language of teachers is more often Arabic. Similarly, collaboration and coordination among development partners outside their focus area (e.g. prevention, research, health, education) may be difficult. **"I think the key is education and [familiarization] of inspectors, teachers, health specialists [and] actors involved in health promotion in their roles."**

Schools in different regions in Tunisia differ widely in resources, priorities and needs, and the differences are most marked between rural and urban schools.

"Rural schools, for example, [may] lack the basics, even access to water … students have to walk a few kilometres to get to school. A great difference is also found [in] the level of knowledge of teachers (usually lower in rural areas)."

In schools, while teachers are still the main providers of health education, lack of training and lack of supervision may limit their actions.

Enablers to implementing the school health programme

Some enablers to the school health programme support progression towards a broader, whole-school approach to health promotion in Tunisia. One key informant said that, **"… progressively, we are in a logic of reform. We have understood that we need to introduce changes in the way we conceptualize education in Tunisia."**

Furthermore, the current school curriculum in Tunisia includes a number of health topics: healthy eating, vaccination and communicable diseases in primary school; sexuality in the ninth basic year; and risk behaviour at university. Other health promotion activities address the themes of International days, such as tobacco control, AIDS, diabetes and rabies, and national days, such as preschool health day and Maghreb week. These are opportunities to enhance the current curriculum and school operations in which a whole-school approach to promoting health could be embedded.

Sustainability of the school health programme

A number of barriers were reported to directly influence the sustainability of the programme. High staff turnover in Government ministries and insufficient resource allocation were considered key reasons for lack of a broader whole-school approach to promoting health. One of the two key informants said that resources should be allocated specifically to the school health programme, as currently health staff are spread across the system.

"Since 2017, many health staff have retired and due to the revolution and then economic crisis, there have not been new recruitments. Health staff in the system are overwhelmed. In addition, school doctors working on prevention in education settings are the same doctors treating in health centres."

Advocacy for cross-sectoral linkages (health and education) would result in adoption of a broader, whole-school approach to promoting health, with development of a decentralized task force (perhaps at regional or local level) to develop a system and processes. **"Sensitize decision-makers on the importance of promoting student health and its impact on schooling and prevention of school failure."**

One key informant listed knowledge gaps that should be addressed in future research to ensure progress towards a broader approach to promoting health in schools,

"allowing [us] to better understand the context and develop strategies to help schools and regions to prioritize based on their needs and bring the main stakeholders [the ministries of Health and Education] together." "For us, recognition or accreditation of HPS is very far away."

Table 8. Summary for Tunisia

Key features of school health organization

- A school health programme is delivered in public and private schools throughout Tunisia, essentially by the ministries of Health and Higher Education.
- Local and regional governments are responsible for implementing decisions made by the Ministry of Health for the school health programme, which includes a doctor, head of department and school supervisor.
- Schools should have a school health team (doctor and nurse).
- Development partners such as WHO, UNESCO, UNFPA and UNICEF support the ministries of Health and Education at central and regional levels and in schools in implementing health activities and conducting research.

Implementation barriers

- Educators, parents and caregivers prioritize student academic achievement over other outcomes.
- Structural challenges at ministerial level (e.g. high turnover) has limited progress towards a broader, whole-school approach to promoting health.
- There is no dedicated budget for promoting health in schools.
- There is no real monitoring or evaluation of projects or mechanisms for implementation.
- Different languages are used by health professionals and by teachers.
- The priorities and needs of rural schools differ markedly from those of urban schools.

Implementation enablers

- The school curriculum includes health topics.
- The value of a broader, whole-school approach to promoting health is recognized; however, HPS is seen as an ideal approach that is not currently feasible in view of the existing barriers.

Sustainability of school health policies

- Broad advocacy about the importance of collaboration between health and education is necessary to gain support for a whole-school approach to promoting health.
- Further research should be conducted on supporting schools and local governments in identifying and prioritizing needs and selecting and implementing strategies to promote health in schools.
- A cross-sectoral, multi-stakeholder task force should be established to create a system for health promotion in schools, adapted to the Tunisian context.

Ukraine

Ukraine is a country in eastern Europe with a population of 43.7 million, 6.4 million (14.6%) of whom are of school age (5–18 years) *(49)*. Ukraine's education system is overseen by the Ministry of Education and Sciences in Kyiv. In 2018, education was extended from 11 to 12 years and now comprises 4 years of elementary schooling, 5 years of middle-school education and 3 years of upper-secondary (specialized) education. This scheme is to be implemented in three stages according to the three levels of schooling, starting at elementary level in 2018, middle school in 2022 and secondary school in 2027. Public education will continue to be free and compulsory up to grade 9 *(50)*.

How is "school health" defined and conceptualized in Ukraine?

On 25 May 2020, the President of Ukraine endorsed the National Strategy for Building a Safe and Healthy Educational Environment. The term "HPS" is not used in this strategy, but the strategy acknowledges that **"… all pillars and all parts of HPS were involved using this whole school approach."** The vision for school health in Ukraine stated in the national strategy is based on a whole-school approach, with the view that all schools can implement a whole-school approach to promoting health, which should be based on the strengths of each school. The whole-school vision was developed with WHO, and UNESCO and UNICEF participated through various projects and initiatives. The strategy demonstrates strong support for health promotion in schools and signifies recognition of the importance of health in education in Ukraine.

"What became quite new in the whole understanding and approach of health-promoting schools was very much [the] social environment, which came through the theme, [the] recognition [of health in education] became more obvious not just because of our initiative but in general due to changes in society."

What are the organization and infrastructure of the National Strategy for Building a Safe and Healthy Educational Environment in Ukraine?

The National Strategy was recently signed, and a memorandum of understanding was signed between the President's wife and UNICEF, which establishes an agreement for cooperation in supporting learning and the healthy development of children and adolescents in the Ukraine.

During development of the National Strategy, a pilot study of HPS was conducted in 22 schools, supported by a Ministry of Health project with WHO, "Noncommunicable diseases: Prevention and health promotion in Ukraine (2015–2019)". For the pilot study, the Health Index Self-assessment tool of the United States Centers for Disease Control and Prevention *(51)* was adapted to identify the strengths, gaps and priorities for health promotion in each school. The key informant noted that the **"… health-promoting schools concept is very useful. In a way, we were missing practical tools, and this was where health index self-assessment tool was useful for us."** In addition, a training package was developed for all school staff and not only school nurses, in recognition of the fact that other staff should also understand health and the components of healthy lifestyles, including the role of the school social environment in health and education.

"… during our pilot stage, we developed a training package for school nurses first, and later on we realized that we need to train staff, all school staff on what is health and what is a healthier lifestyle and the components it has, so that they can work as a team, promote health through different angles, and set their own example to children."

The pilot study of HPS and the resulting National Strategy occurred at a time of extensive reform in Ukraine, such as greater decentralization of funding for education.

"This is changing in Ukraine since independence, and we are also in the process of decentralization reform as well where regions are getting more authority to decide and fundraise and there are also changes in financial flows to the regional level."

All schools are intended to implement the National Strategy; however, because both the memorandum of understanding and the National Strategy were signed during the early stages of the COVID-19 pandemic, a national action plan for implementation of the Strategy is still pending.

Who is involved in the National Strategy for Building a Safe and Healthy Educational Environment?

Many organizations and agencies are involved.

National Government

The Strategy was approved by the Cabinet Minister. The Ministry of Health initially led development of the Strategy, in collaboration with the Ministry of Education and Science, which was appointed lead ministry for development of the action plan to implement the Strategy and also for its monitoring and evaluation, in cooperation with the Ministry of Health.

Development partners

In the Ukraine, four United Nations partners provided support for testing various initiatives in schools and also contributed to development of the Strategy. UNFPA provided support in the area of sexual and reproductive health, UNESCO supported the area of sexual education and overall education reform, and UNICEF provided support for comprehensive child and adolescent health and education and for development of the Strategy. The role of WHO was described by the key informant: **"For the last 5–6 years, [WHO] were supporting the Government to develop a comprehensive strategy and pilot approaches on health promoting schools using whole-of-school approach."**

Schools

The staff of all the schools in the pilot study were trained and involved in implementing HPS, including local fund-raising to supplement national Government funding. Parents, caregivers and local community organizations were involved in implementation of the Strategy, particularly in fund-raising.

Monitoring and evaluation of the National Strategy for Building a Safe and Healthy Educational Environment

While full implementation of the National Strategy in all schools has been delayed during the response to the COVID-19 pandemic, the key informant indicated that a **"whole system of monitoring and evaluation has to be developed"** and that **"monitoring and evaluation … is also an important part that requires a lot of work to build and support the strategy implementation."**

The ministries of both health and education will be involved in monitoring and evaluation, in line with their responsibilities. It is expected that indicators and data collection tools will be included in the action plan for implementation of the National Strategy.

Barriers to implementing the National Strategy for Building a Safe and Healthy Educational Environment

Several potential barriers were reported to implementation of the National Strategy at scale, many of which were identified in the pilot study.

Specific practical tools are required for implementation that are designed for the Ukrainian context and also for monitoring and evaluation. **"… the strategy itself is not enough for implementation, actually the strategy has to be supported by the detailed action plan."**

"again here [reference to monitoring and evaluation], we do not have the tools. When we were developing these final expected results of the strategy and we started to think about monitoring and evaluation, we realized that we do not have clear indicators, we do not have clear tools where we can have a look and adapt it to Ukrainian needs …."

Two further potential barriers were reported. The first is a general lack of health expertise in schools. **"They don't have enough up-to-date information on health, nutrition [and] physical activity."** Similarly, an appropriate level of funding is required. While schools and regional governments can and do raise funds in their local communities, funding may still be limited. Reliance solely on fund-raising could be a barrier to implementation if sufficient funding cannot be raised or if considerable time is required. This is a particular concern, as the drain of resources is likely to be greater than usual as a result of the COVID-19 pandemic.

"I think one of the barriers for implementation might be discussion of budget …. Ukraine is a lower–middle-income country, and funds are scarce in any area. Of course, as we mention, some schools and regions are quite creative to raise funds, but definitely funding will be a barrier."

Enablers to implementing the National Strategy for Building a Safe and Healthy Educational Environment

There are several enablers to implementation of the National Strategy in Ukrainian schools. First, the existence of the National Strategy is an enabler, as it indicates political commitment to the concept of HPS. **"I think political commitment is key…. It was very useful to have a President decree that a strategy has to be developed."**

A further enabler is the embedding of a participatory approach into the design of the National Strategy, which not only ensures that health promotion builds on the strengths of schools but can also result in an increased sense of ownership of health promotion among school staff, students and the local community. Use of a self-assessment tool ensures that strengths can be defined precisely, and implementation can target and capitalize on those strengths.

"The whole idea of a participatory approach was very useful as well. Where they describe this is not for someone for inspection or for research; this is to raise capacities, raise understanding of the school authorities what needs to be done to promote health in these schools."

"[The school staff] were so glad … that created this kind of participatory approach."

School autonomy in the management of funds and for raising funds for school activities is also an enabler of implementation, particularly when national funds distributed to regional governments are anticipated to be insufficient.

A focus on improving the well-being of teachers and all school staff within the National Strategy was considered another enabler, similarly to the participatory approach, as it can encourage ownership and provide opportunities for all school staff to adopt healthy behaviour. **"What we also included is consideration of health of school staff and that was completely new…. That this school environment is not only for kids but for health of school staff."**

Sustainability of the National Strategy for Building a Safe and Healthy Educational Environment

At the time of writing, the sustainability of the National Strategy was unknown because its implementation has been halted by the COVID-19 pandemic. The key informant indicated that the sustainability of the Strategy, and of any approach to promoting health in schools, will depend on sustained political commitment, sufficient resources and clear, evidence-based guidance.

"The next step in this kind of initiative [is that] we need to think how already established platforms of mechanisms [can be used], how parents may be more active in health promoting activities and their understanding of what needs to be done in schools, and how they can influence [health promotion in schools]."

While a national strategy has been endorsed in the Ukraine, the key informant stressed that continued collaboration and support from development partners and other countries remain important for sustained implementation.

Table 9. Summary for Ukraine

Key features of school health organization

- The National Strategy for Building a Safe and Healthy Educational Environment has been endorsed the President of Ukraine. Development of the strategy was led by the Ministry of Health, and development of an action plan for implementing the strategy is to be led by the Ministry of Education.
- Both ministries will be responsible for monitoring and evaluating implementation of the Strategy according to their portfolios.

Implementation barriers

- Lack of practical and contextually relevant tools for implementation
- Lack of health expertise among school staff
- Insufficient financial and human resources

Implementation enablers

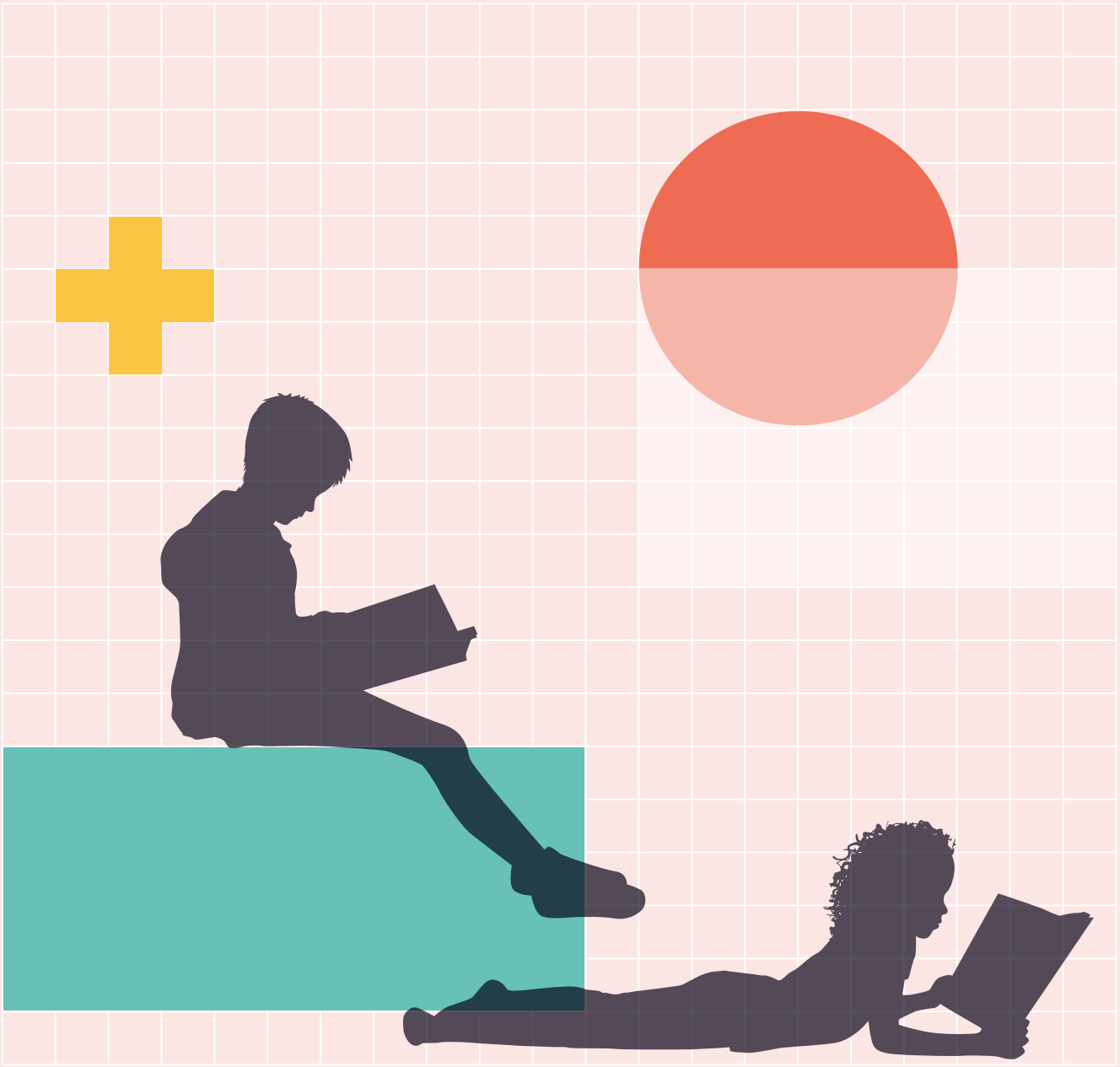
- Existence of a national strategy for health promotion in schools
- Embedded participatory approach to health promotion in schools
- School autonomy to raise funds
- Explicit focus on promoting the health and well-being of school staff as well as of students and the local community

Sustainability of school health policies

- Clear, evidence-informed implementation guidance for the National Strategy
- Continued collaboration with development partners

Common findings from the case profiles

Several common findings for implementation of health promotion in schools were identified in the eight case profiles.



Common findings

1. The HPS approach was considered aspirational.

HPS was considered a valuable concept by all the key informants and also in the reviewed documents. The term "health-promoting schools" was not often used, however, in describing the health promotion activities in the eight countries. The main explanation given was that the countries were not comprehensively implementing HPS as defined by WHO and UNESCO. Some key informants considered that HPS would be overly ambitious for their context, while others indicated that health promotion in their countries was advancing and, in time, would result in realization of the concept of HPS.

While gaps were identified between current health promotion practices in schools and HPS, all the key informants considered that the HPS approach was worth aspiring to. They recognized that HPS is distinct from programmatic activities[4] and requires a whole-school approach in which all health promotion activities are connected, coordinated and embedded in school operations, i.e. reflected in school strategic plans, policies and teaching, as well as in the delivery of health services.

2. Many countries are at an early stage of HPS implementation.

Most key informants reported that considerable progress would have to be made before whole-school approaches to health promotion were being used in all schools. A number of informants noted a highly programmatic focus in school health promotion and that programmes, such as those on WASH and nutrition, tended to be implemented discretely. They considered that more effort was required to identify common objectives and outcomes in individual programmes to ensure the greater value of whole-school approaches (e.g. student empowerment). Many informants suggested that conceptualization of current programmes in a wider, whole-school approach, embodied by HPS, would demonstrate gaps and opportunities for leverage across programmes.

In many countries, the findings reflect relatively recent introduction to the concept of whole-school approaches and their resource implications. For example, the few national education policy guidelines and documents that referred to whole-school approaches had been published only within the past 2 years (e.g. the Bhutan National Education Blueprint was published in 2019).

3. Collaboration between the health and education sectors is common.

In all the case countries, health promotion in schools included some collaboration between the health and education sectors, usually at national government level between the ministry or department of health and the ministry or department of education. The ministry or department of education was responsible for health promotion in schools in some countries, while, in others, it was the ministry or department of health.

Development partners were involved in health promotion in most countries, usually for programmatic components of health promotion (e.g. curriculum development, infrastructure), such as for WASH. Partners tended also to support monitoring and evaluation of the programmatic component, either by providing standards and tools for monitoring and assessment or, in Paraguay, conducting aspects of monitoring and evaluation.

Countries that had a documented whole-school approach to health promotion commonly had intersectoral collaboration with local communities. For example, both local health services and human services (e.g. police, social welfare) worked with school personnel in health promotion.

Collaborations based on clear descriptions of roles and responsibilities and structures for collaboration (e.g. communication strategies, formal agreements) tended to be more effective in support implementation of health promotion in schools.

[4] "Programmatic" is defined here as discrete programmes, interviews or health curricula being implemented in a school as discrete projects or in addition to other projects, rather than a holistic programme that involves the whole school community and embeds health promotion within the whole school system *(18)*.

4. National policy and guidance manuals help to embed health promotion in the education system.

Countries with national education policies and implementation plans or guidance manuals that made explicit reference to health promotion and whole-school approaches were more likely to have health promotion in schools embedded in the education system. Furthermore, implementation plans or guidance manuals for a national education policy that referred to a whole-school approach for health promotion often included a step for aligning existing school policies with the national education policy. For instance, in Senegal, health promotion was incorporated into teacher training, and this was viewed very positively by the key informant. In Paraguay, specific teaching resources (e.g. lesson materials) have been developed for classes that include health promotion messages and were considered to be useful for implementation.

National policies and implementation plans or guidance manuals were also reported as enablers for health promotion in schools, because their existence clearly indicated political support and dedicated resources for health promotion in schools. The key informants noted, however, that the existence of a policy or implementation plan did not always result in a dedicated budget for school health promotion.

In the absence of national education policies and guidance materials that referred to a whole-school approach to health promotion, individual schools tended to develop their own policies. The extent to which this occurred depended on the level of support for health promotion in schools by the principal, school governance boards and parent associations (when they were included in school governance).

Because of the timing of the interviews with key informants, a number of them reported that the response to the COVID-19 pandemic had highlighted the importance of health promotion in schools. In some countries, the pandemic response had resulted in the provision of resources for infection control (e.g. soap and hand-washing facilities). Many key informants noted, however, that not only COVID-19 but many other events (e.g. natural disasters) indicate the importance of health promotion in schools in LMICs.

Commonly reported enablers and barriers to HPS

An enabler or barrier was considered to be "common" if it was reported in more than one case study.

Seven common enablers were reported (Table 10). All the key informants reported that sufficient financial resources are necessary for implementing HPS. Most explained that implementation of HPS in their country would require a dedicated budget, which would cover:

- staff salaries,
- operating expenses,
- monitoring and evaluation and
- additional funds for schools and/or resources for training or technical expertise for schools (e.g. health educators or evaluators, depending on the schools' capacity or the role of regional governments).

Table 10. Commonly reported enablers in the country case profiles

Enabler	Bhutan	Indonesia	Paraguay	Philippines	Senegal	South Africa	Tunisia	Ukraine
Sufficient financial resources	✓	✓	✓	✓	✓	✓	✓	✓
National education policies and guidance materials for HPS	✓	✓	✓		✓	✓	✓	✓
School and local community context considered in HPS planning	✓	✓	✓		✓	✓	✓	✓
HPS leadership by the education sector		✓	✓		✓	✓		
School and community ownership of HPS		✓	✓		✓			
Availability of validated tools for monitoring implementation of HPS		✓	✓					✓
Teacher and school leader training in HPS		✓	✓					

"Ticks" show which key informants reported the enablers. They do not indicate that these enablers are currently in place.

Ideally, the funds would be provided by the national government and made available to all schools, whether public, private or associated with faith-based institutions. The funding could be allocated or managed by local or regional governments but should be available for all schools.

National policies and guidance materials for HPS were considered essential for embedding health promotion throughout the educational system. Policies and documents can support teacher and school leader training in health promotion. In countries that had education policies and guidance materials for HPS, those in the education sector were more likely to have a leadership role in embedding health promotion in the educational system, such as in assessing student learning, teacher training and curriculum development.

Another commonly reported enabler was consideration of the context of the local community and school in planning implementation of HPS. When a situational analysis or a needs assessment that involved school staff and/or community members was conducted, implementation of HPS was more likely to address local needs and priorities and schools and the local community had a greater sense of ownership of HPS.

Three common barriers were reported (Table 11). All the key informants reported that insufficient financial resources were the greatest barrier to HPS implementation. Resources were insufficient not only in the amount but also when they were allocated or limited to use in specific programmes rather than for broader use, such as a whole-school approach to health promotion.

Table 11. Commonly reported barriers in the case country profiles

Barrier	Bhutan	Indonesia	Paraguay	Philippines	Senegal	South Africa	Tunisia	Ukraine
Insufficient financial resources	✓	✓	✓	✓	✓	✓	✓	✓
Contextual disparities between rural and urban areas			✓		✓	✓	✓	
Health workforce shortages		✓	✓		✓			

"Ticks" show which key informants reported the barriers. They do not indicate that these enablers are currently in place.

Another challenge is tailoring HPS implementation for schools in rural and in urban areas. Key informants in some countries reported that rural schools were more likely to have inadequate infrastructure and facilities, such as toilets. Poverty was frequently noted in rural schools, and some students had to walk long distances to attend school. The informants considered, however, that there are also opportunities for HPS implementation in schools in rural areas. In some countries, parents and caregivers in rural areas were more active in supporting school operations, and the example was given of parents who worked in agriculture providing fresh fruit and vegetables for school nutrition programmes.

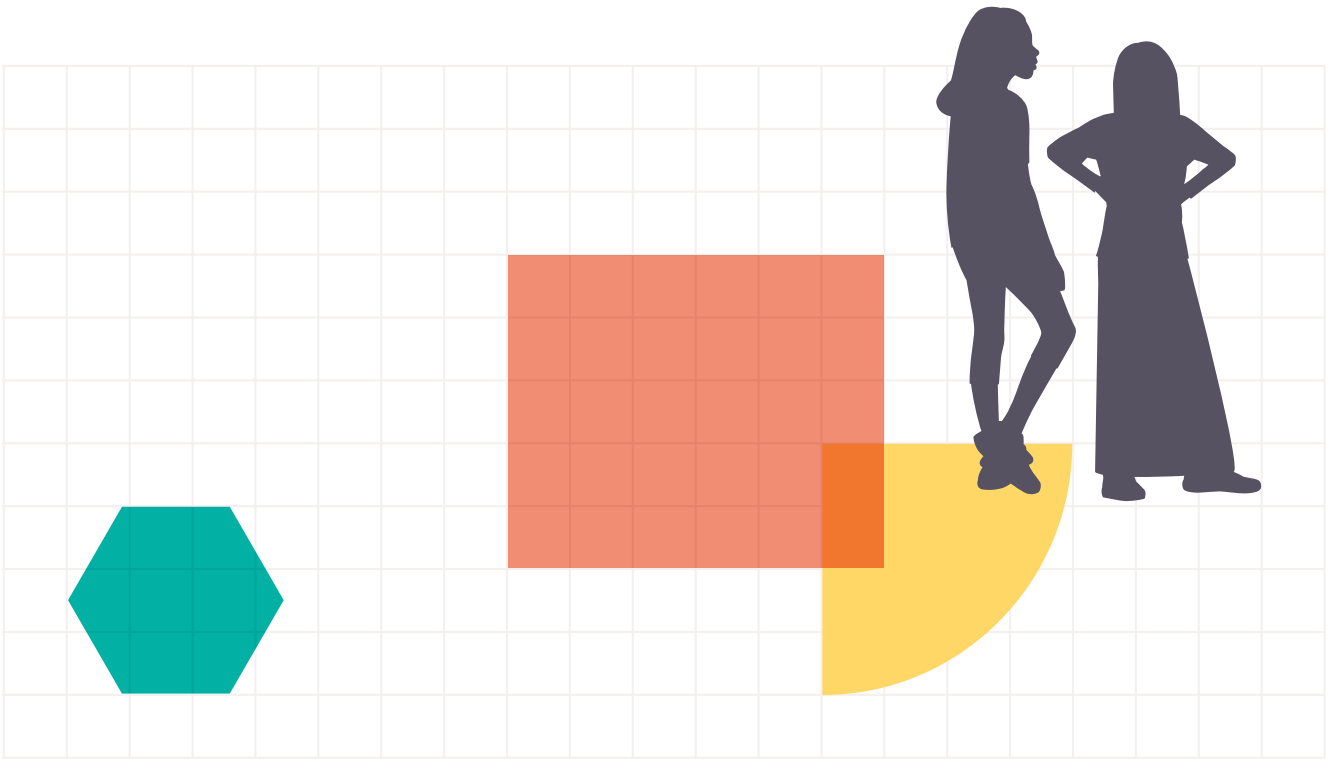
Health workforce shortages were reported by several key informants as a barrier to HPS implementation. When there were shortages, the health workforce tended to focus on acute health needs and were more likely to be based in secondary and tertiary health care settings rather than in primary care, resulting in a lack of health staff to provide services in schools. One means to mitigate workforce shortages is to invest in increasing the comprehensiveness and quality of health education training for teachers and school staff, thus minimizing reliance on health professionals for delivery of health education in schools.

The fact that fewer barriers were reported than enablers should not be interpreted as indicating fewer barriers than enablers overall but rather that there were fewer common barriers. Barriers were often specific to a country, such as resource allocation methods for health promotion or geographical distribution of regional or local health services. The barriers could be mitigated by considering the enablers when implementing HPS. While some of the barriers are not modifiable (e.g. disparities between rural and urban settings), strategies for the enablers, such as explicit consideration of contextual factors in planning HPS, would minimize the negative impact of the barriers on HPS implementation.

Conclusion

The eight country case profiles provide examples of health promotion in schools in LMICs in the six WHO regions. The identification of barriers and enablers demonstrates specific challenges and also opportunities for implementing HPS in LMICs. These case profiles demonstrate the perceived value of the HPS approach for LMICs, with a shift towards whole-school approaches offering opportunities for health and education for all students rather than responding to specific health and developmental concerns that might negatively affect learning. The key informants indicated that the challenges of the COVID-19 pandemic on health and education further highlighted the importance of the HPS approach.

Notwithstanding the strong support for HPS expressed in the case profiles, the relative novelty of HPS and whole-school approaches to health promotion in the case countries is apparent, both in national governments and in the United Nations agencies and development partners that support them.



Recommendations

The global standards for HPS and their implementation guidance are intended to describe HPS and what they include (global standards) and to show how HPS can be implemented sustainably (implementation guidance) *(25, 26)*. The primary readership of the standards and the guidance will be national governments; however, the findings of these eight country case profiles suggest several recommendations for supporting HPS implementation that are relevant for both national governments and implementing agencies.

Recommendations

1. Formulate a strategy for communicating the global standards for HPS and the implementation guidance to national governments and implementing agencies.

Once the global standards and the implementation guidance have been finalized and undergone global consultation, they should be widely circulated to national governments and also to implementing agencies, given their support to countries. Endorsement of these documents by national governments and implementing agencies is encouraged.

2. Conduct analyses of key school health programme areas (e.g. WASH) to identify links and opportunities to align these programmes with a whole-school approach.

The case profiles show the extent to which United Nations agencies and development partners still drive programmatic interventions in schools in many LMIC. It is therefore important that these organizations facilitate opportunities for HPS and do not inadvertently undermine the commitment to make every school a health-promoting school. Implementing agencies could work together to identify programmes that could benefit from conceptualization within a whole-school approach. The exercise might include mapping of policy documents to identify means for aligning them with HPS through the global standards.

3. Prepare policy briefs on specific topics as examples of how programmes can be conceptualized in the whole-school approach, as set out in the global standards and their implementation guidance.

The results of mapping could indicate how specific interventions (e.g. WASH, nutrition, mental health) can be conceptualized in a whole-school approach to HPS. A series of topical briefs could be prepared, which could include examples from both LMIC and high-income countries. The readership of such briefs might be national governments and also implementing agencies.

4. Continue developing indicators for HPS, and conduct research and evaluation of HPS.

The case profiles show that local and national evidence should be shared globally to understand the effectiveness of different HPS implementation approaches in various settings. Some key informants highlighted the importance of indicators, monitoring plans and evaluation tools for HPS that can be used or easily adapted to different settings in LMIC. Monitoring and evaluation are closely related to sustained implementation and investment in HPS; investment in the former can support the latter.

The country case profiles of HPS highlight the importance of continuing to collect evidence from across the globe as part of ongoing work to support every school in becoming a health-promoting school.

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Annex. Data collection tools

Pre-interview questionnaire: HPS case studies

WHO and UNESCO have announced an initiative for "Making every school a health-promoting school" with development and promotion of global standards for HPS. The initiative will serve over 1.9 billion school-age children and adolescents. WHO defines a health-promoting school as "a school that is constantly strengthening its capacity as a healthy setting for living, learning and working". HPS have been recognized as strategic for promoting positive development and healthy behaviour, such as physical activity, physical fitness, recreation and play, balanced nutrition, no tobacco use and prevention of bullying.

To inform development of the global standards and the implementation guidance, WHO and UNESCO commissioned two reviews of evidence, which were undertaken by the Centre for Adolescent Health, Melbourne, Australia, a WHO Collaborating Centre for Adolescent Health. A key finding of this work was the lack of peer-reviewed literature about the barriers and enablers of HPS in low- and middle-income countries; most studies were from high-income countries.

WHO and UNESCO contracted the Centre for Adolescent Health, Murdoch Children's Research Institute, to complement the reviews by consulting key informants and preparing a number of case studies for deeper understanding of the barriers and enablers of implementation of HPS in low- and middle-income countries. Eight countries were identified by WHO and UNESCO, and key informants (of which you are one) were nominated in each country on the basis of their role, interests, experience, contributions to the field and background knowledge of HPS or similar approaches.

The purpose of this brief questionnaire is to collect some information about implementation of HPS or related health and education policies and approaches in your country. Its main purpose is to provide context for the more detailed interview that will follow.

This document is a guide to the questions you will be asked in the interview. The purpose of the interview is to understand your views on HPS, implementation of HPS or related health and education policies in your country, any challenges experienced and the relations among the ministries and agencies involved. We are particularly interested in understanding:

- **collaboration among organizations, sectors and the school community** (including parents and caregivers) in HPS or related health and educations policies;
- **governance, monitoring, accountability, resources** (including funding) for HPS in schools, the government and agencies;
- **the relations and roles of government, external agencies and schools** in day-to-day implementation of HPS or related health and educations policies; and
- **lessons from implementing HPS or related health and education policies in your country** that could inform global standards and guidance on implementation.

You are welcome to raise other issues and topics that will help us understand implementation of the HPS or related health and education policies in your country. The information from this interview will be used to *describe* implementation of HPS and related health and education policies.

Consent

The information obtained from the case studies will be used to inform the future global standards and implementation guidance, and the information collected from the following brief questionnaire will be used as a basis for the interview in which you have been asked to participate as a key informant. The information you share in the questionnaire and interview is confidential and will be used to develop a country case study. All data will be securely stored on password-protected servers at the Murdoch Children's Research Institute or the University of Melbourne. De-identified information may be shared with WHO and UNESCO country offices for development of the global standards and implementation guidance for HPS.

This study is being conducted by Professor Susan Sawyer, Dr Monika Raniti, Kristina Bennett, Cristina de Nicolás Izquierdo and Dr Ruth Aston at the University of Melbourne and Murdoch Children's Research Institute, Melbourne, Australia.

I understand that:

- the information I share will be used to develop a country case study report by the listed researchers, and the report will be shared with WHO; this consultation may inform the global standards and implementation guidance for HPS; and
- the interview I participate in will be audio-recorded with my consent.

If you have any questions or concerns about this project, please contact Professor Susan Sawyer by email on susan.sawyer@rch.org.au. Please indicate your consent to participate in the questionnaire and interview, if you choose to do so.

The questionnaire begins on the following page.

Thank you!

☐ Yes, I agree to participate in the questionnaire and recorded interview.

☐ No, I do not wish to participate in the questionnaire or the recorded interview.

Personal information	
1. Name:	
2. Title:	
3. Gender:	
4. Agency, ministry or organization:	
5. Position and duration in position:	
6. How is your current role related to implementation of HPS in schools in your country?	
7. Have you held other roles related to implementing HPS in your country or another jurisdiction?	
8. Contact details	Email: Phone: Preferred language for the interview: ☐ English ☐ French ☐ Spanish

Key informant interview questions

Section A: Background of HPS or related health and education policies

1. How would you describe the HPS approach?	
2. Do you think the importance of health in education is recognized in your country? If yes, why? If no, why not? a. In your view, what is needed to improve recognition of the importance of and relation between health and education in your country?	
3. What are the characteristics of the organization and provision of education in schools in your country that are important in relation to implementation of HPS or related health and education policies?	
4. To what extent is the choice to implement HPS or related health and education policies in your country voluntary for schools? a. How do schools decide to become involved in implementing HPS? b. If it is mandatory, how are schools supported or encouraged to implement HPS or a related health and education approach? c. Do regions and/or school characteristics differ in e.g. early childhood, primary, secondary education?	
5. To what extent are dedicated resources provided for HPS or related health and education policies in your country? a. Who (what organizations) provides the resources, and how are they allocated and distributed?	

Key informant interview questions

Section B: Role of government and external agencies in HPS or related health and education policies

6. What is the government's role in HPS or other health and education policies in your country? a. In what aspects does the government have the most influence in implementation of HPS or other health and education policies? b. Which ministry or ministries are responsible for developing, encouraging or enforcing implementation of HPS or other health and education related policies in your country? i. If several ministries are responsible, how do they work together? ii. Are regional or more local organizations involved? How do they work with the ministry(ies)? iii. Do the roles and responsibilities of ministries and organizations differ for different school types (e.g. primary and secondary, urban, more regional and rural schools)?	
7. How would you describe the involvement (if any) of external agencies (e.g. WHO, UNESCO, UNICEF, UNFPA, World Bank and nongovernmental organizations) in HPS or other health and education policies in your country? a. How do these agencies work with the ministry(ies)?	

Key informant interview questions	
Section C: Design of the HPS or related health and education policies	
8. Is the design of the HPS or related health and education policies in your country most similar to which of the following? a. *curricular intervention* (embedded in classroom teaching, perhaps aligned with the health curriculum, e.g. the language of HPS is used, and teachers conduct assessment or student work aligned with HPS); b. *programmatic intervention* (a clear set of activities with a beginning and an end); or c. *whole-school intervention* (embedded in school strategic goals or policies, e.g. restricting the types of foods students can bring to school)?	
9. What is the role of parents and families in implementation of HPS or related health and education policies in schools?	
10. What is the role of school staff and the wider school communities (teachers, other community organizations in other sectors) in implementation of HPS or related health and education policies in schools?	
11. How culturally relevant is the design of the HPS or related health and education policies to schools and communities in your country?	
12. Please describe the practices of implementing HPS or related health and education policies in schools in your country.	

Key informant interview questions	
Section D: Tracking the progress of HPS or related health and education policies in schools	
13. Is there accountability for implementation of the HPS or related health and education policies? a. To what extent does it include monitoring and evaluation? b. If yes, are data gathered, what data are collected and by whom? c. How are the data used? Are they publicly reported? How is progress in HPS reported?	
14. What would happen if a staff member from a ministry or organization involved in HPS or health-related policies visited a school and observed that incorrect messages about nutrition were being shared with students and the wider school community?	
Section E: Current status of implementation of HPS or related health and education policies in schools	
15. How would you rate the current status or progress of implementation of the HPS or related health and education policies in schools in your country on a scale from 1 to 10, where 10 is full implementation, in which all HPS or health and education polices is fully embedded and well implemented? a. Please give a reason for your rating. b. Are there any important patterns or areas of variation in the progress?	
16. What, if any, outcomes have you observed as a result of implementing the HPS or related health and education policies in schools? a. Are there any important patterns or areas of variation?	
17. What factors (e.g. human and financial resources, policies, school culture) *hinder* implementation of HPS or related health and education policies in schools in your country?	
18. If sufficient resourcing was available, what factors would *support* implementation of HPS or related health and education policies in schools in your country?	

Key informant interview questions	
Section F: Sustainability of HPS or related health and education policies in schools	
19. With current resources (including personnel capacity and capability, financial resources) for all those involved in implementation of the HPS or related health and education policies in schools, how sustainable is current progress in implementation?	
20. With current resources (including personnel capacity and capability, financial resources) for all those involved in implementation of the HPS or related health and education policies in schools, how sustainable are the outcomes you have observed?	
21. If there were sufficient resources and if implementation of HPS or related health and education policies at a school were successful, what would you expect to see in 5 years' time? How different would the situation be from the current situation?	
22. Could any other contextual factors (e.g. socioeconomic, political, social, humanitarian) help us to understand the main challenges and opportunities for implementation of HPS or related health and education policies in your country?	
23. On the basis of our discussions, how useful would global standards and implementation guidance be for HPS in your country?	
24. Would you like to share anything else with us?	

HPS Implementation

The next set of questions refers to implementation of HPS or related health and education policies. We are interested in understanding the extent to which support and guidance are provided by the government and external agencies or organizations to schools in implementing HPS or related policies. Please share any documents or websites that also provide information on these questions, with the name, whether they are available online and the website address. In the interview, we will build on the questions listed below. The information you provide here will help us to ensure that the questions we ask are relevant.

1. Is there a policy, strategy and/or national guidelines related to HPS or other health and education policies in your country?	☐ Yes Please describe: ☐ No
2. Are any external agencies (e.g. WHO, UNESCO, UNICEF, UNFPA) involved in the development and implementation of HPS or health and education-related policies in your country?	☐ Yes Please describe: ☐ No
3. Which ministries (and other organizations) are responsible for the development and implementation of HPS or health and education-related policies in your country?	
4. Is implementation of HPS or health and education-related policies monitored and evaluated in your country?	☐ Yes Please describe: ☐ No
5. Do you have any comments you would like to share before the interview?	

Thank you for taking the time to complete this questionnaire.

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