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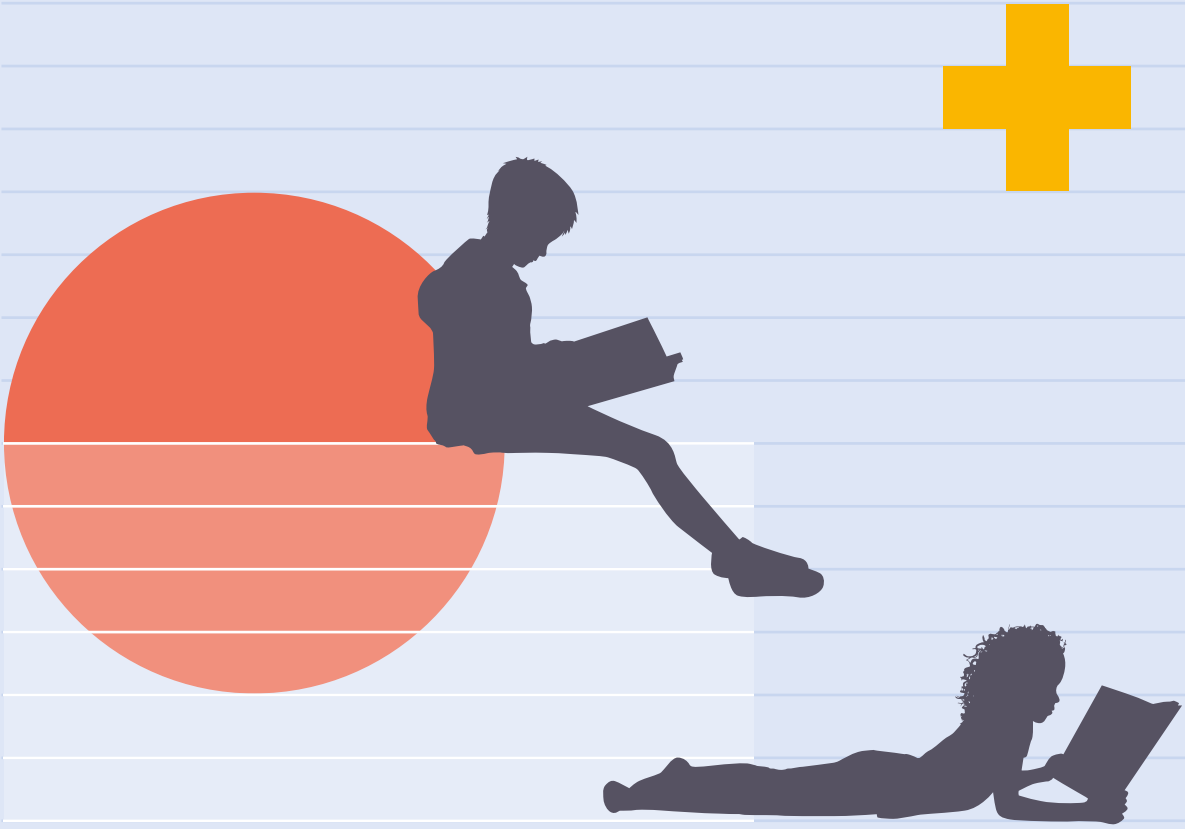

Making every school a health-promoting school

Implementation guidance

Education 2030

World Health Organization

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Making every school a health-promoting school: implementation guidance

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Contents

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 severely disrupted education, prevented an estimated 365 million primary school students from having school meals and significantly increased the rates of stress, anxiety and other mental health issues. Experience tells us that, in some parts of the world, when schools close for more than a few weeks, early and forced marriage, early pregnancy, child labour and domestic violence increase.

The right to education and the right to health are core human rights and are essential for social and economic development. Now, more than ever, it is important to make all schools places that promote, protect and nurture health; 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, 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.

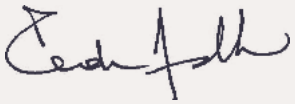
No education system can be effective unless it promotes the health and well-being of its students, staff and community.

Every education system should have institutionalized policies, mechanisms and resources to promote health and well-being in all aspects of school life, including the teaching curriculum and school governance based on participatory processes that are inclusive of the broader community. This requires that education systems be re-oriented 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 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, case studies illustrate how health promotion in schools is being implemented in low- and middle-income countries.

Application of 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".



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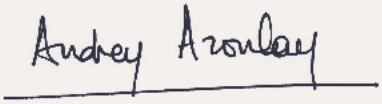

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Abbreviations and acronyms

HPS	health-promoting schools
HSS	healthy school strategy
PISA	Programme for International Student Assessment (OECD)
UKS	*usaha kesehatan sekolah* (school health programme in Indonesia)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestinian Refugees in the Near East
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

Glossary

Area (implementation): In this implementation guidance, a thematic statement describes an area of implementation, and each area has a matched set of strategies, which are action-oriented statements that contribute to implementing the area. Some areas contain additional descriptive statements of quality implementation of the area.

Capacity development: the process through which individuals, organizations and societies as a whole unleash, strengthen, create, adapt and maintain capacity over time to set and achieve their development objectives. It includes training and other learning activities as well as improvements in systems to create conditions for applying new knowledge, practising new skills, improving performance and ensuring sustainability.

Community of practice: "Group of people who share a passion for something that they know how to do and who interact regularly to learn how to do it better" *(1)*

Comprehensive (health services): the extent to which the spectrum of care and range of services respond to the full range of health problems in a given community. Ideally, comprehensive services address all health areas relevant to their student population, including: positive health and development; unintentional injury; violence; sexual and reproductive health, including HIV; communicable disease; noncommunicable disease, sensory functions, physical disability oral health, nutrition and physical activity; and mental health, substance use and self-harm. The term "comprehensive" is used in this document consistent with the WHO guideline on school health services *(2)*.

Co-scholastic: Usually refers to teaching, learning and assessment of life skills, attitudes, values and co-curricular activities (e.g. physical education)

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" *(3)* that enables students "to develop skills, knowledge and an understanding of their own health and well-being and that of their community" *(4)*. The curriculum encompasses the totality of students' experiences that occur in the educational process and it includes planning and development and students' educational experience beyond the classroom.

Deep learning: A method of learning in which knowledge is not only memorized and understood but also synthesized and applied *(5)*.

Differentiation: Use by educators of a range of teaching techniques and lesson adaptations to respond to the diversity of students' readiness, interests and learning needs.

Distributed model of school leadership (also referred to as "shared leadership"): Collaborative, interdependent leadership, including decision-making, that is shared among individuals at all levels of the school community *(6)*.

Educational outcome: The desired learning objectives that schools, teachers and other school staff wish students to achieve, including academic achievement, the learning experience and the educational, societal and life effects of education, including school completion and employment *(7)*.

Evaluation capacity-building: Strengthening the monitoring and evaluation capacity of individuals, organizations, communities and networks to include evaluation in order to improve results.

Governance: The rules, mechanisms, relationships and processes through 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" *(8)*.

Health education: Any combination of learning experiences designed to help individuals and communities improve their health by increasing knowledge, influencing motivation and improving health literacy. Can include communication of information on the determinants of health, individual risk factors and use of the health care system. Can involve task-based communication to support predetermined actions such as participation in immunization and screening programmes, adherence to medication or health behaviour change. Can also include skills-based communication to develop generic, transferrable skills for health that equip people to make more autonomous decisions about their health and to adapt to changing circumstances. Includes knowledge and skills to address the determinants of health.

Health literacy: Health literacy represents the personal knowledge and competence that accumulate through daily activities, social interactions and across generations. Personal knowledge and competence are mediated by the organizational structures and resources that enable people to access, understand, appraise and use information and services to promote and maintain good health and well-being for themselves and those around them.

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" *(8)*. 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 education system: An education system that, through intentional, planned actions, institutionalizes health promotion in all its functions, i.e. governance of the educational process and its content, resource allocation, educators' professional development, information system and performance management.

Health-promoting school: A school that consistently strengthens its capacity as a safe and healthy setting for teaching, learning and working *(9)*. 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 *(10)* 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 throughout the process *(11)*. Particularly in schools, implementation is considered to represent complex interactions among the characteristics of the education system, implementers and the organizational context in which a programme is implemented *(12)*.

Indicator: A variable used to monitor or evaluate specific, measurable progress towards completion of an activity, output, an outcome, goal or objective *(13, 14)*. Indicators are provided for the components of each global standard. Indicators can be populated from various data sources and can be collected and reported at various levels (e.g. global, national, subnational, school). The different types of indicator are *(15)*:

- Input indicator: used to monitor human and financial resources, physical facilities, equipment and operational policies for implementation of programme activities;
- Process indicator: used to monitor activities carried out to achieve the objectives of a programme, including what is done and how well it is done;
- Output indicator: used to monitor the results of processes in terms of service access, availability, quality and safety;
- Outcome indicator: used to monitor the intermediate results of programmes that are measurable at population level;
- Impact indicator: used to monitor the long-term outcomes that programmes are designed to affect, including decreases in mortality and morbidity.

In-service teacher: Teacher who are both registered and employed as a teacher in a school.

Intersectoral collaboration: A working relation between two or more sectors to achieve health and education outcomes in an effective, efficient, sustainable manner *(16)*.

Knowledge translation: Synthesis, exchange and application of knowledge by relevant stakeholders to accelerate the benefits of global and local innovation in strengthening education systems and improving student's health and well-being.

Local community: Both the local (geographical) community of people living or working near the school and various organizations external to the school but 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.

Logic model: A graphic that presents the relations among goals, objectives, implementation strategies, activities and their intended effects.

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

Paedagogy: The theory, method and practice of teaching, including teaching styles and feedback and assessment.

Pre-service teacher: Students who are enrolled in an initial educator preparation programme and studying for teacher certification.

Professional learning: Formal and informal learning experiences undertaken by teachers and other school leaders to improve both individual and collective professional practice, the effectiveness of which is often measured by improvements in student learning, engagement with learning and well-being. Professional learning encompasses and can improve the knowledge, skills and processes of school professionals.

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

Scholastic: Academic achievement and the practice and behaviour of learning, e.g. studying.

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 governance (e.g. school board members), management staff, other school staff (e.g. administrative staff, cleaners, health professionals) and volunteers who work in the school, students, 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 *(17)*.

Social–emotional learning: Specific areas of the school curriculum and "… the process through which children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, make responsible decisions…" *(18, 19)*. An inherently strengths-based approach intended to equip students with the personal resources to enable them to cope better with challenging circumstances.

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.

Standard: A statement that defines characteristics, structures, processes and/or expectations of performance expectations *(20)*.

Standard statement: The overarching descriptor of a global standard.

Subnational: Political–administrative units that operate at the level of a state, region, province, municipality, district or zone. Countries have different levels of school governance.

Substance use: Use or self-administration of a psychoactive substance, which may include alcohol, caffeine, tobacco, marijuana, opioids, over-the-counter medications and other licit and illicit drugs *(21, 22)*.

Sustainability: The degree to which an initiative is maintained over time or institutionalized in a given setting *(23)*.

Well-being: A physical, emotional, mental and social state "in which every individual realises his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community" *(24)*.

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" *(3)*. 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 *(25)*.

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.

This publication is based on an extensive review of global evidence on the barriers to and enablers of implementation, maintenance and scaling-up of the health-promoting school approach. Its aim is to guide adaptation and implementation of the global standards for HPS.

National and subnational stakeholders in all sectors involved in identifying, planning, funding, implementing, monitoring and evaluating the HPS approach will find this publication useful for understanding:

- what should be done,
- how it should be done and
- who should be involved

in making every school a health-promoting school.

Towards making every school a health-promoting school: Let's start by consulting this guidance, which is based on the best available evidence on the enablers of and barriers to implementation.

Health Promoting Schools are everyone's business.

This requires multi stakeholder engagement.

Introduction

Health-promoting schools

Schools are increasingly seen as an important setting for promoting the health, development and well-being of children and adolescents. Schools promote long-term educational attainment and support the health and well-being of students, their parents and caregivers and the local community.

The interactive, mutually reinforcing relations between health and education endure well beyond formal schooling *(26)*. Supporting schools in promoting health while building the knowledge, skills and competence of children and adolescents offers considerable benefits for individuals, families and communities.

A whole-school approach to the promotion of health and well-being is one in which all members of a school community are committed to working collectively and collaboratively to support student learning behaviour and well-being beyond the classroom and in all aspects of school life *(25)*.

An international body of evidence (including systematic reviews of interventions, from randomized controlled to non-controlled trials) shows that whole-school approaches to promoting health and well-being can increase academic achievement, student attendance and retention at school, in addition to providing widespread benefits for the health and well-being of children and adolescents, school staff and the wider local community *(27–30)*. Whole-school approaches have also been tested in other areas of school reform (e.g. inclusive education), with similar educational outcomes *(27)*.

A health-promoting school is "a school that is constantly strengthening its capacity as a healthy setting for living, learning and working" *(26)*. The concept of health-promoting schools embodies a whole-school approach to promoting health and educational attainment in school communities by using the organizational potential of schools to foster the physical, social–emotional, and psychological conditions for health as well as for positive education outcomes *(27)*.

HPS initiatives and other whole-school approaches to support health in education have been implemented for several decades, and there is wide recognition that the uptake and sustainability of HPS is globally necessary *(31–33)*. Health-promoting education systems are necessary to ensure sustainability by institutionalizing health promotion in all functions of the education system, such as governance of the educational process and its content, resource allocation, educators' professional development, information systems and performance management.

Accordingly, in 2018, WHO and UNESCO announced an initiative to "make every school … a health-promoting school" and develop and promote global standards and indicators for HPS *(34)*. The aim was to support their implementation by government departments and ministries, school staff, civil society organizations and international partners. A standards-driven approach that includes guidance for implementing HPS is expected to strengthen whole-school approaches to health promotion worldwide.

This United Nations initiative responds to the recommendation in the Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation *(35)*, that "every school should be a health-promoting school". A number of other global initiatives to support health in education reinforce this initiative, including the Sustainable Development Goals, the UNESCO education strategy for 2014–2021 and global management of public health emergencies such as the COVID-19 pandemic.

Development of the implementation guidance

This implementation guidance for HPS accompanies the global standards and indicators for HPS *(34)*. The global standards for HPS provide a vision in which all schools, everywhere, can enhance the health, well-being and educational outcomes of their students and communities. This requires that schools move beyond specific health topics and programmes to embrace a whole-school approach to promoting health and well-being, in which the culture, conditions and curriculum of a school all contribute to an HPS system.

The eight global standards for sustainable HPS systems are listed in Table 1. More information on how the standards were developed is provided in volume 1 *(34)*. The standards are designed to support whole-school approaches to promoting health in educational settings.

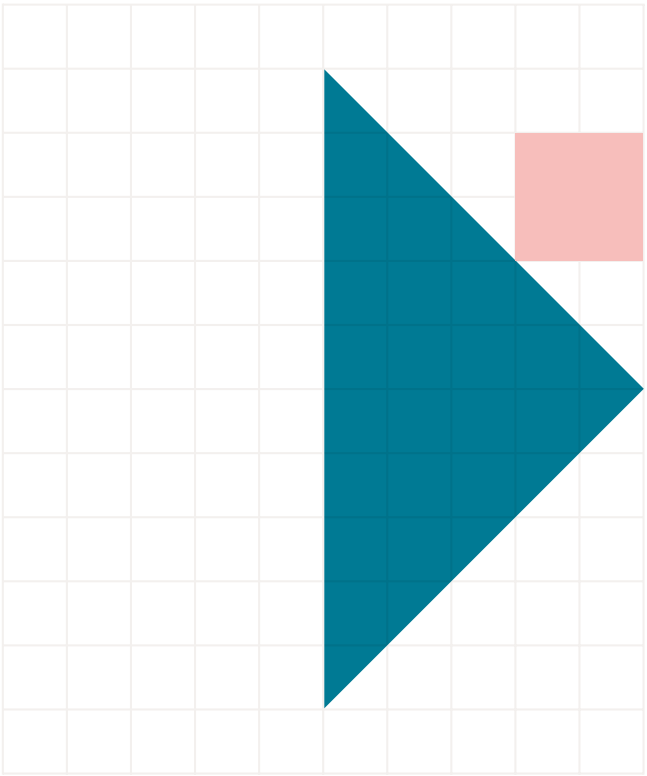
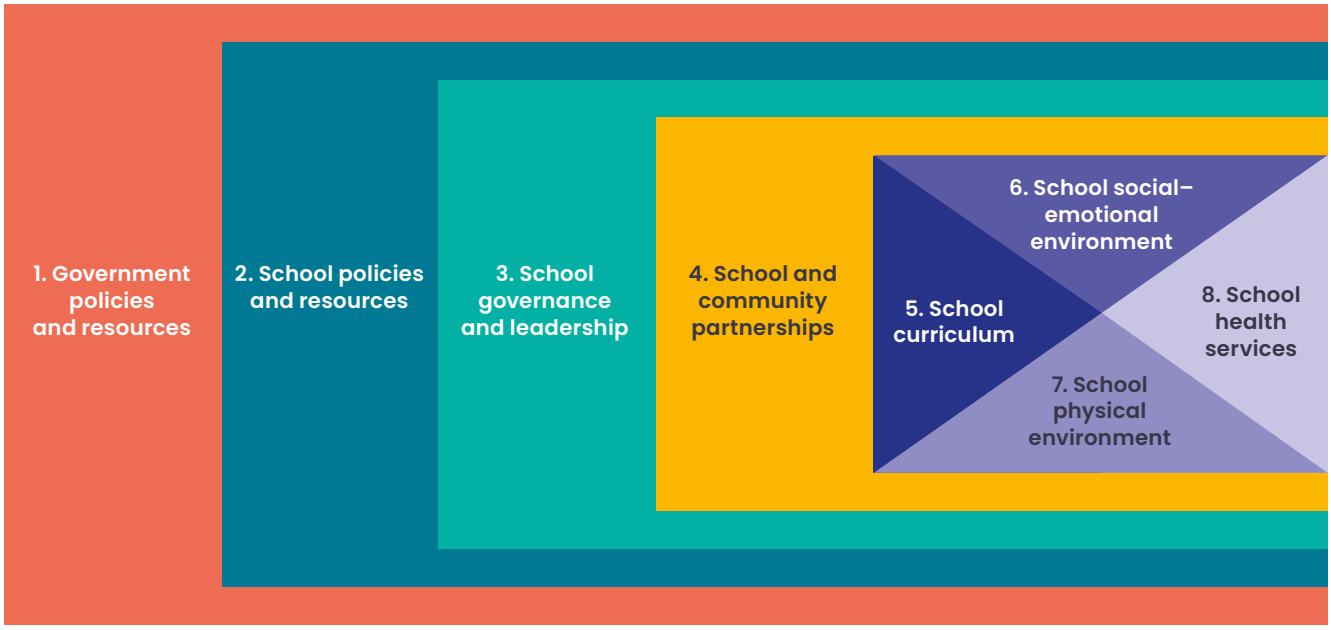


Table 1. Global standards and standards statements

1 **Government policies and resources** The whole of government is committed to and invests in making every school a health-promoting school.	2 **School policies and resources** The school is committed to and invests in a whole-school approach to being a health-promoting school.	3 **School governance and leadership** A whole-school model of school governance and leadership supports a health-promoting school.	4 **School and community partnerships** The school is engaged and collaborates with the local community for health-promoting school.
5 **School curriculum** The school curriculum supports physical, social–emotional and psychological aspects of student health and well-being.	6 **School social–emotional environment** The school has a safe, supportive social–emotional environment.	7 **School physical environment** The school has a healthy, safe, secure, inclusive physical environment.	8 **School health services** All students have access to comprehensive school-based or school-linked health services that meet their physical, emotional, psychosocial and educational health-care needs.

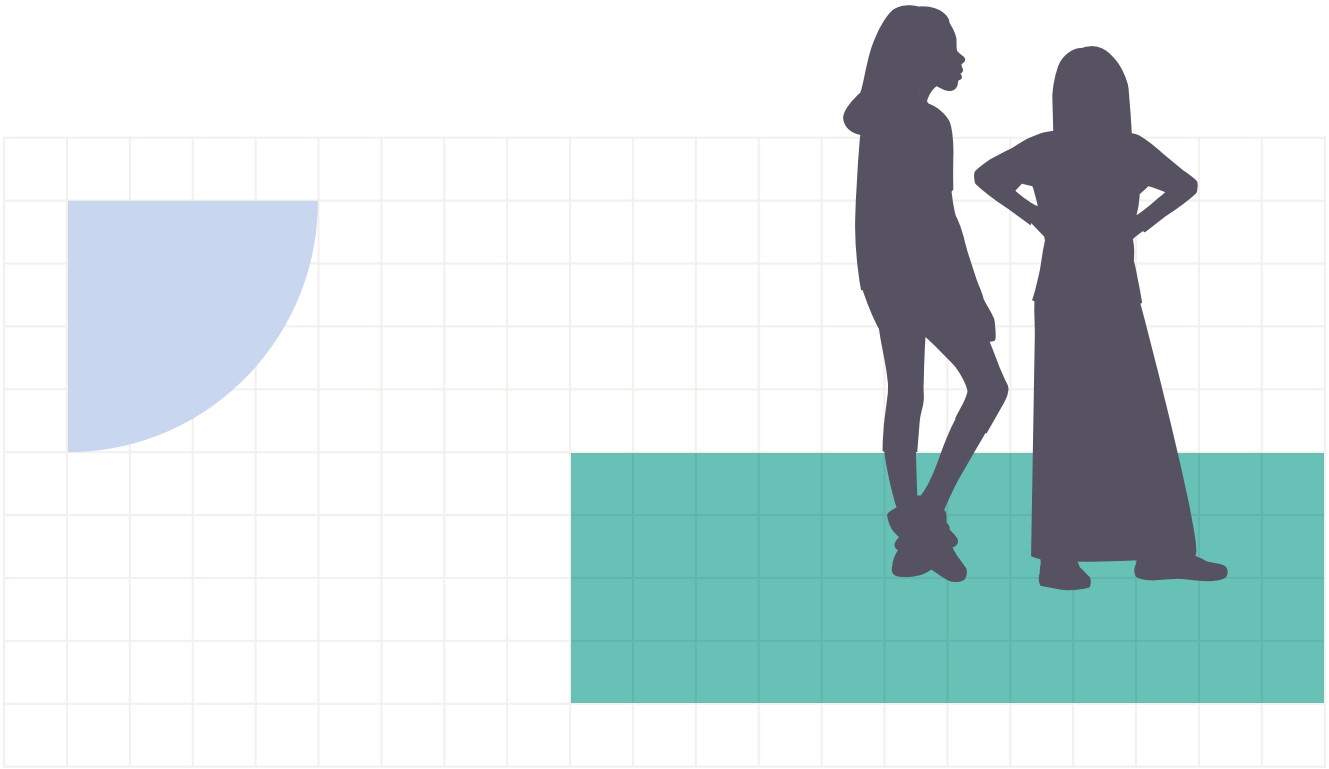
The eight global standards are intended to comprise an HPS *system,* as shown in Fig. 1 (more detail is provided in reference *34*).

Fig. 1. System of global standards for health-promoting schools



As in the global standards, the implementation guidance uses the term "HPS" generically, to include other whole-school approaches, such as comprehensive school health and education, *éducation pour la santé, école en santé, estrategia* or *entorno escuela saludable* and *escuela para la salud*.

Like the global standards, this implementation guidance is based on two evidence reviews *(31, 32)*, a series of case studies from eight low- and middle-income countries *(36)* and consultations with a global external advisory group and a wider group of stakeholders.



Aim of the implementation guidance for HPS

The purpose of the implementation guidance for HPS is to assist national, subnational (where relevant) and local governments in *developing, planning, funding and monitoring* sustained whole-school approaches to health promotion in schools. The approaches enable governments to meet the nationally and locally relevant health and well-being priorities of students, parents, caregivers, school staff and local communities.

The aim of the guidance is to support the establishment of structures and mechanisms for uptake of the global standards for HPS and embedding them in the education sector. Thus, the guidance promotes leadership in the education sector and intersectoral collaboration for promoting health and well-being in schools. The implementation areas, strategies and practical lessons described are directly aligned with the global standards for HPS.

The guidance is thus designed to assist relevant government officials in deciding *what* should be done, *how* it can be done and *who* should be involved in adopting and applying the global standards for HPS.

This document complements other manuals and guidelines, such as the standards and indicators of Schools for Health in Europe *(37);* documents of the Focusing Resources on Effective School Health (FRESH) initiative, a collaboration of WHO, UNESCO, UNICEF and the World Bank to improve the quality and equity of education; and the WHO/UNAIDS global standards for quality health-care services for adolescents *(20).*

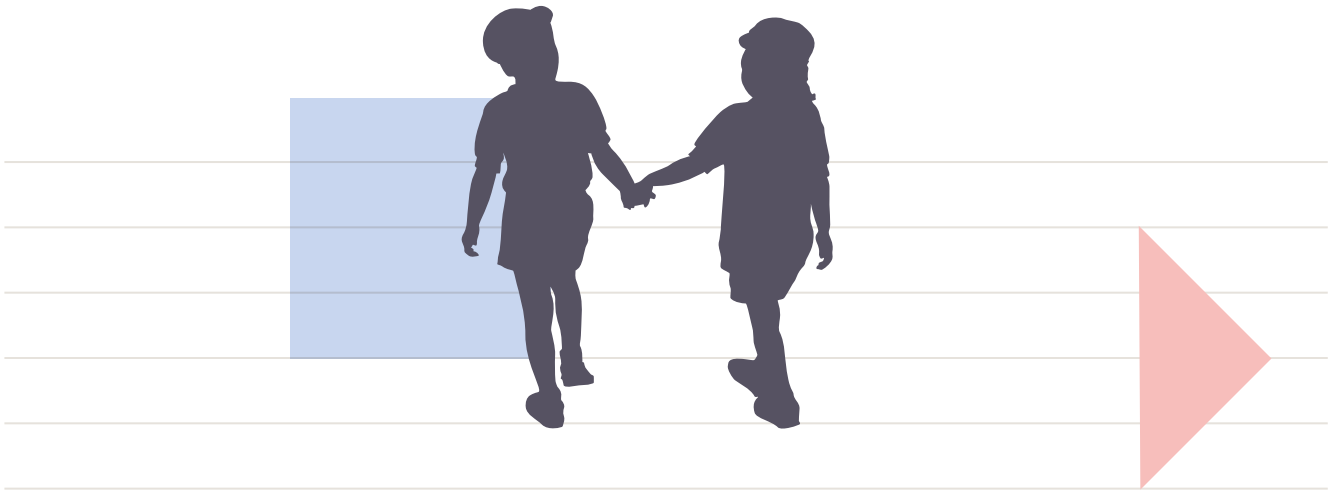
The implementation guidance should be read in conjunction with the global standards for HPS (volume 1) and the country case studies (volume 2).

Target readership

The readership of this guidance is therefore mainly people in government who are responsible for policy development, planning, resource allocation and monitoring (e.g. school performance reviews) of school health and health promotion programmes. They include staff in relevant ministries and sectors, especially education, health and associated sectors (including social services, housing, employment, agriculture and culture) and policy-makers in all sectors.

Depending on the governance structures of education in a country, the guidance may be more relevant for national, subnational or local government officials. For example, when jurisdictional governments are involved in the provision of education, the guidance may be particularly relevant to subnational officials.

While school staff and others involved in the provision of school-based education are not the primary readership, this guidance will also be relevant for school leaders; however, additional material (e.g., manuals, tools) will be required to implement HPS at school level (see, for example, the SHE manual in Annex 2).



Guiding principles

Several principles should guide implementation of the global standards, which state the common characteristics of a sustainable HPS system. Although the approach to or design of HPS will differ by country according to its context *(36)*, the principles should be reflected in all settings.

1. HPS implementation is inclusive and equitable.

Sustainable HPS systems must include all members of the school community in all aspects of their design, management and operations to ensure equitable progress towards health and education outcomes. This principle is relevant both between schools (e.g. the needs of students in rural schools may be different from those in cities or slums) and within schools (e.g. the needs of disadvantaged students, students living with disabilities, girls and students and staff who are or are perceived not to conform to mainstream or conventional norms related to gender, sexuality and reproductive health, should be considered).

2. The governance system for HPS implementation is embedded in the education sector.

Governance consists of the rules, mechanisms, relations 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. Political support and buy-in to HPS implementation at scale are necessary for governance.

The global standards indicate that sustained implementation of HPS requires collaborative governance at many levels (national, subnational, local government and school) within the education sector. Embedding HPS into various aspects of the education system, such as resource allocation, educators' professional development, information system and performance management, will be easier if governance of HPS is led by the education system. Nevertheless, the governance system also requires partnerships, collaboration and coordination within and between stakeholder groups in education, health and associated sectors and at many levels of government and schools.

3. HPS implementation reflects a whole-school approach.

The global standards show that the scope of HPS is broader than any specific programme or intervention, as important as they are. Whole-school approaches to health and well-being also require supportive relationships, safe, gender-equitable physical and social environments and greater opportunities for learning in the school as a social community. Accordingly, the design, management and operations associated with implementing HPS must also reflect a whole-school approach, in which activities incorporate all aspects of schooling. For example, programmes and curricula should be reinforced by school policies, manifested in school infrastructure and supported by collaboration with groups in the local community. They should also be reflected in classroom lesson plans and co-scholastic activities, enhanced by professional learning and reflection on practice among in-service teachers and ideally in local or national achievement tests for students.

4. HPS implementation involves all stakeholders and particularly students, parents and caregivers.

The global standards reflect the importance of meaningful engagement, participation and responsibility by all stakeholders, including students, parents and caregivers. This assists implementation and may also mutually reinforce health and well-being, Children and adolescents, especially girls, are given opportunities to be empowered as agents of change and advocates for health promotion in their families and local communities. Strong, sustained engagement and participation of students in health promotion and wider leadership in schools can positively influence lifelong learning, development, health and well-being.

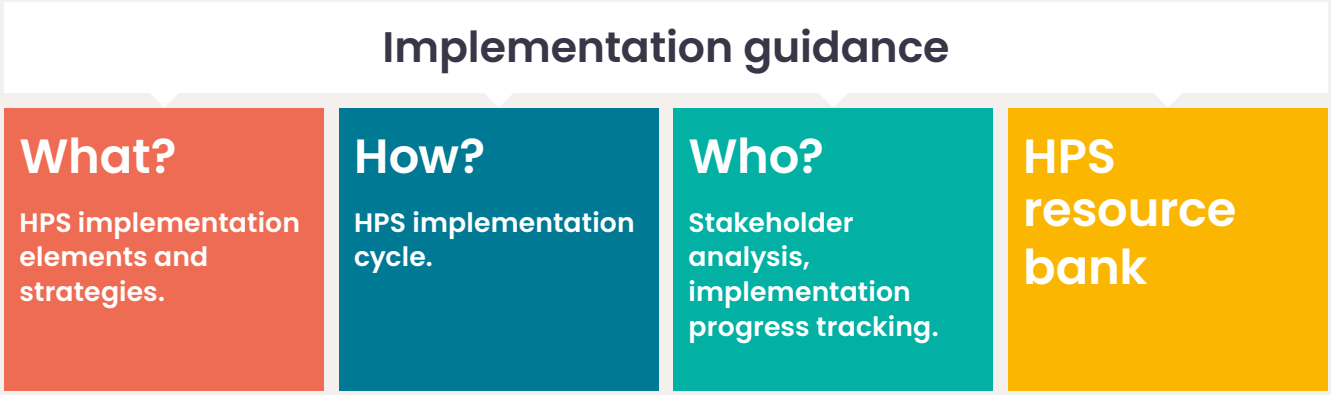
5. HPS implementation is iterative and continuous.

The aim of the implementation guidance is to guide an iterative, process-driven approach to progressive embedding of the global standards for HPS in all schools. The approach should build on policies and strategies that are already in place *(36)*, which will be supported when ministries of education see HPS as an important attribute for every school. Implementation is a continuous cycle that responds to emerging, current (e.g. the COVID-19 pandemic) and school-contextual priorities and which will eventually lead to sustainable promotion of health and well-being, reflected in the day-to-day roles of school staff and the ethos of schools.

Areas of implementation guidance

This implementation guidance for HPS has four parts (Fig. 2). Part 1 describes "How" to implement HPS; part 2, "What" must be done to implement HPS (13 implementation areas and strategies); and part 3, "Who" should be involved (implementation stakeholders). Part 4 provides a resource bank of published checklists, reports and tools to support HPS implementation.

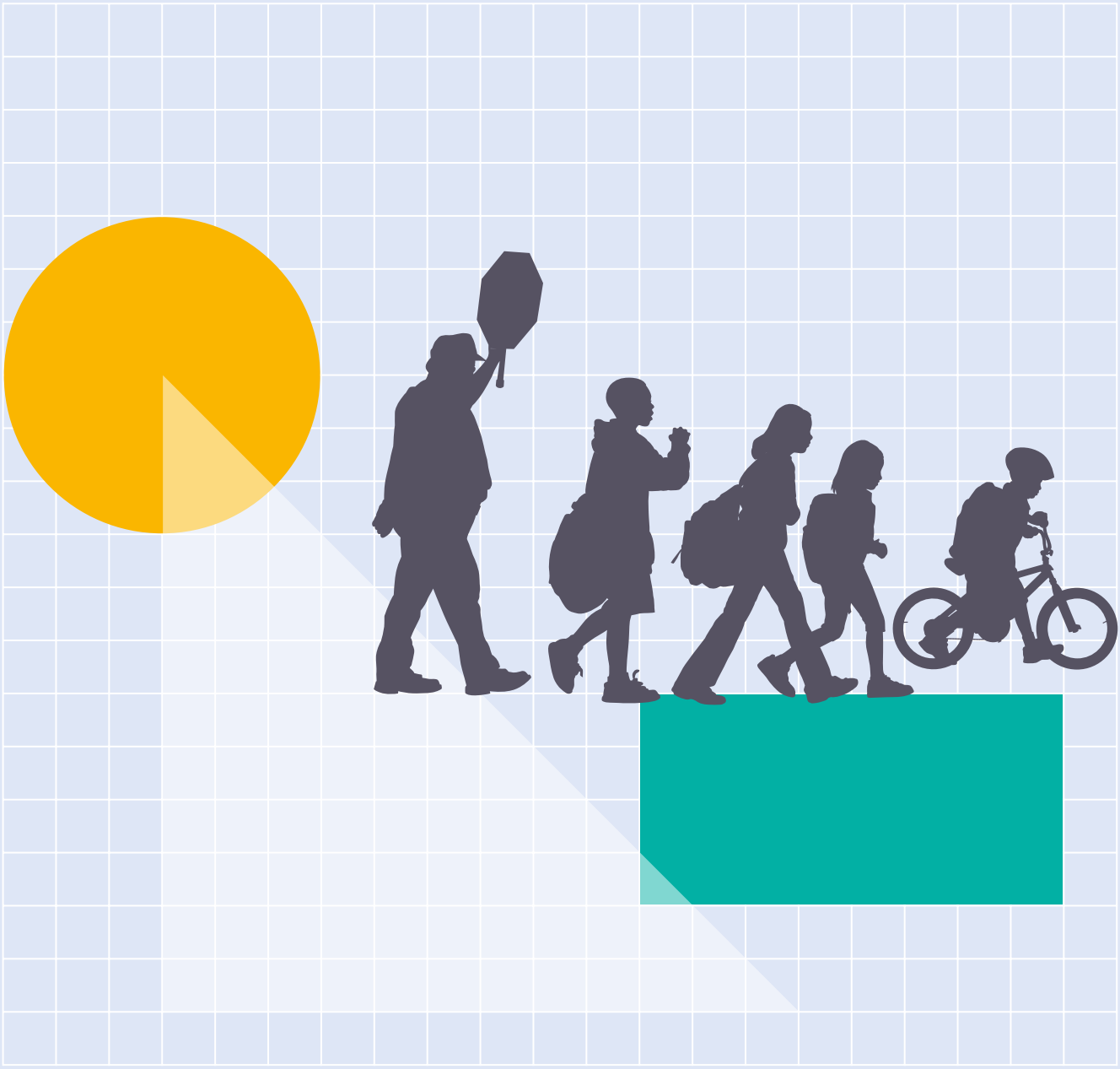
Fig. 2. Components of implementation guidance



The following sections describe the who, what and how. The 13 implementation areas and strategies are supported by lessons from evidence *(31)* and practice as shown in examples drawn from country case profiles *(36)*. Annex 1 provides detailed mapping of how each implementation area is aligned with the global standards for HPS, and Annex 2 lists resources to inform planning, design, monitoring and evaluation of HPS systems.

Part 1

Implementation cycle



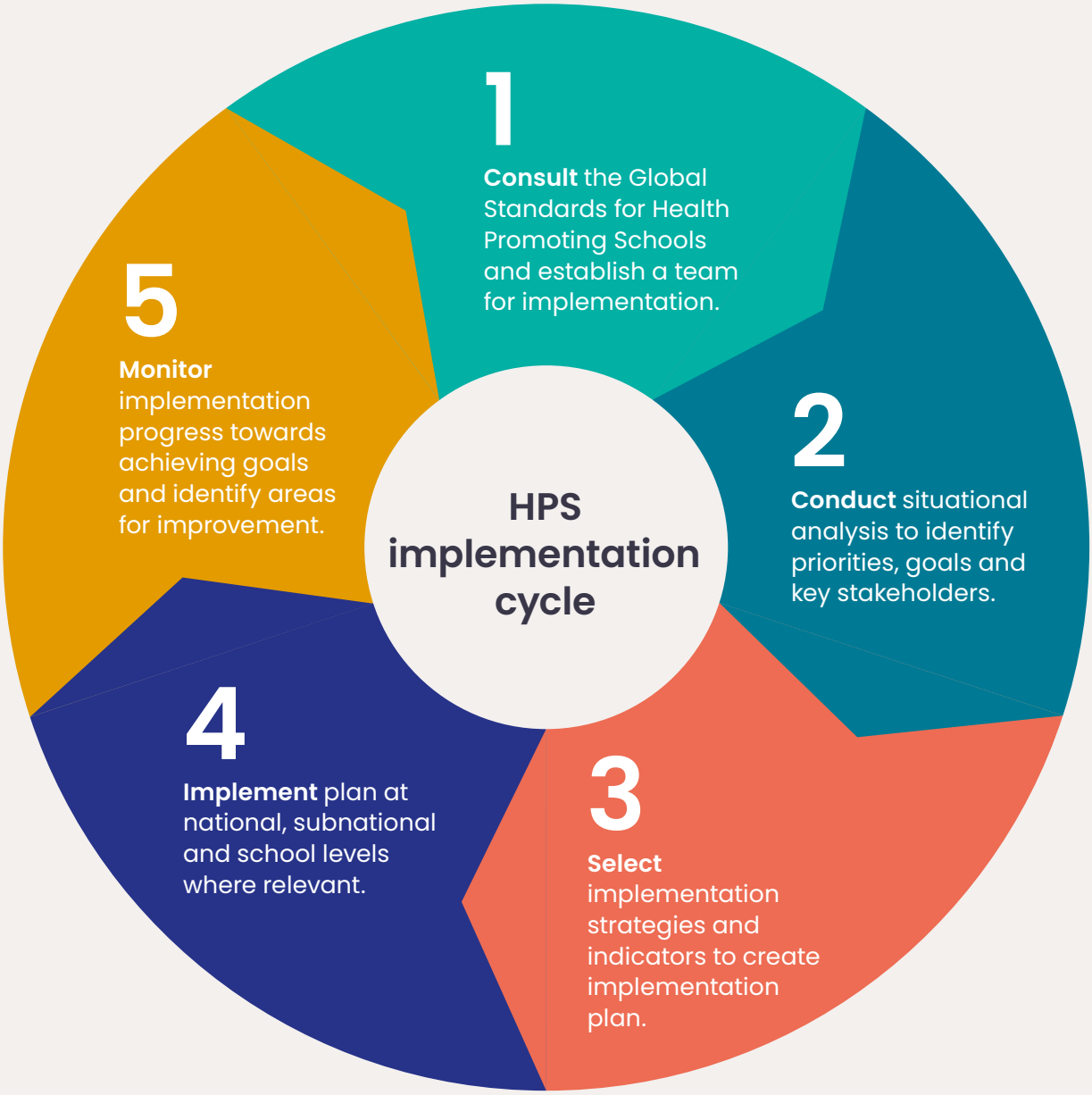
This section describes *how* the global standards for HPS can be adapted and implemented in a step-wise cycle. The implementation cycle is proposed for continuous, iterative implementation of HPS over time.

The cycle is relevant for national, subnational and local governments and school leaders. While each step of the cycle is a scaffold for the next, not only national government officials can conduct each step, and the steps are similar whether a national policy-maker or a school principal is implementing the cycle, although a school principal will be implementing the steps in their school and a national government official will be implementing them for a country. A national government official is expected to make policy decisions that enable a school principal to implement the cycle.

Annex 2 provides additional resources for planning implementation, including examples of country- and school-oriented manuals and guides.

The implementation cycle has five steps (Fig. 3).

Fig. 3. Overview of the HPS implementation cycle



The implementation cycle should be based on the guiding principles. The process cycle is repeated throughout HPS implementation and is applicable in countries with different levels of experience in this approach (see Table 3) *(36)*. The cycle is similar to the annual planning and strategic review cycles applied in many national and local governments and schools. In practice, aligning the timing of the cycle steps with annual planning or strategic reviews will assist in embedding HPS implementation throughout the education system.

The areas of implementation guidance that support each of these steps are indicated on the right of Fig. 3. The purposes of and activities for each of the five steps of the implementation cycle are described in Table 3.

Table 2. The five steps of the HPS implementation cycle

	Purpose	Activities
Step 1. Consult the global standards, and establish a team.	Ensure a common understanding of HPS, and establish a team for implementation.	• Hold a national orientation meeting(s) to sensitize and orient school health focal points from education and health ministries, relevant government agencies and implementing partners. • Consult the global standards *(34)* to ensure a shared understanding of the global guidance for HPS at all levels of government departments in health, education and other relevant sectors. • Establish a intersectioral and multisectoral team of stakeholders who represent all the groups involved in implementing HPS
Step 2. Analyse the situation.	Identify existing HPS activities and key stakeholders, and set goals and targets for HPS.	• Conduct a situation analysis of existing school health and education policies (national, subnational, local and school-level, where relevant) and compare them with the eight global standards and context (e.g. emerging or new health needs). A tool for gap analyses in comparison with global standards is presented in Annex 2. • Review international or regional recommendations, policies and initiatives for HPS, and consider whether national adaptation is necessary. • Map stakeholders (see stakeholder mapping exercise, p. 30)). • Analyse the strengths, weakeness, opportunities and threats (SWOT) of current HPS activities and practices to identify areas in which HPS systems can strengthen policies and strategies for health and well-being. Use the 13 implementation areas and their strategies as a checklist to assess current HPS activities and practices. A tool for gap analysis in comparison with the implementation strategies is provided in Annex 2. • Review the available human, information and financial resources allocated to schools for all aspects of health and well-being. • Review current monitoring and evaluation frameworks for education and health outomes to identify opportunities for embedding HPS.

	Purpose	Activities
Step 3. Develop a plan	Develop a plan for implementation at national, subnational and school levels to strengthen HPS systems.	• Use the results of the situation analysis (step 2) to adapt the Global Standards nationally, and secure formal endorsement. • According to the results of the situation analysis (step 2), select the strategies for realizing priorities and goals for HPS (see *Implementation areas and strategies*). Establish priorities and goals for HPS in both the short term (e.g. 12–15 months) and the longer term (e.g. to inform national strategies and plans). • Use a logic model or equivalent to collaborate with students, parents, caregivers, school leaders, school staff and the local community to document implementation of HPS based on priorities and goals. • Identify how HPS implementation can be embedded in education systems and school processes, such as national education strategies, school strategic planning, school councils or governance boards. • Estimate a budget, describe the roles and responsibilities of stakeholders, set a timeline and targets for HPS (e.g. apply for funding, advocate for additional budget from local government). • Develop or review a plan for monitoring HPS, including indicators, appropriate collection tools and the frequency of data collection. Use the indicators listed in part 4 of the global standards *(34)*. • Disseminate the implementation and monitoring plans.
Step 4. Implement and monitor the plan.	Implement the plan in collaboration and partnership with school staff, students, parents and caregivers.	• Use the plan to implement HPS at all levels (e.g. national, subnational, local, school), and document adaptations required during implementation (e.g. in a living logic model). • If HPS cannot be implemented nationally (e.g. no expereince in implementing HPS approaches), identify districts and schools that have adopted HPS to learn from initial implementation. (See Table 2 for various implementation scenarios.) • Use the plan to monitor HPS implementation, and analyse monitoring data regularly to inform adaptations. • Collect feedback on implementation from all stakeholders, including school staff, students, parents, caregivers and the local community.

	Purpose	Activities
Step 5. Evaluate and improve the plan.	Monitor implementation, review, reflect and share lessons, and identify areas for improvement	• Review and reflect on the the results of analysis of monitoring data, and determine whether targets have been met. • Share the findings of the analysis of monitoring data with all stakeholders, including school staff, students, parents, caregivers and the local community, to identify areas for improvement. • Disseminate success stories and lessons learnt from HPS implementation to stakeholders, particularly within and between schools, and to partners and coordination groups in national and local government, as well as to nongovernmental organizations and development partners. • Identify areas for improvement, and go back to step 1 to plan a new cycle to continue institutionalization of national standards within the education sector.

In summary, this section provides a five-step process for how to implement the global standards for HPS. The next section provides details on what strategies (grouped in 13 areas) can be used as part of steps 3 (reviewing current activities and practices) and 4 (developing a plan for implementation).

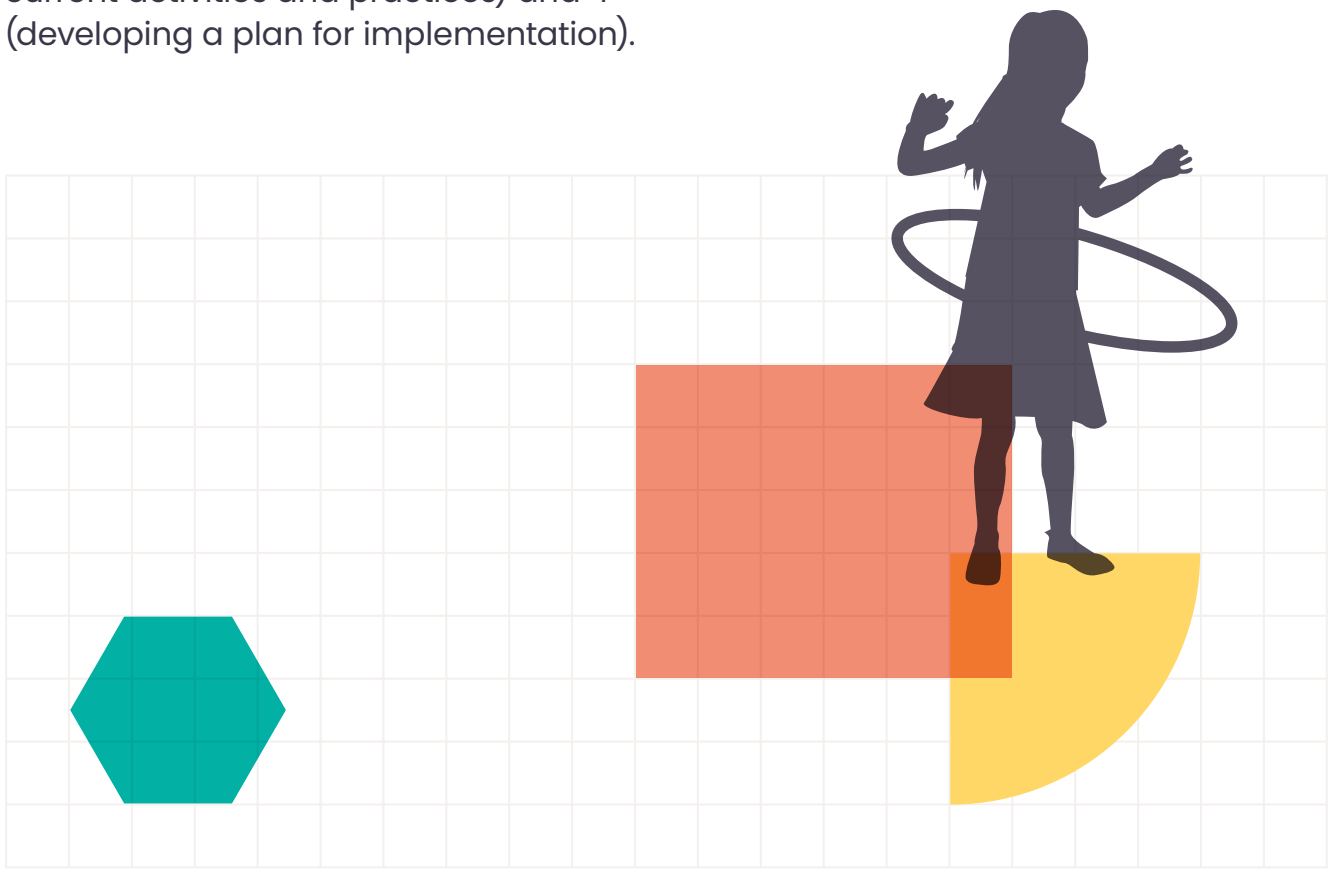


Table 3. Application of the global guidance in countries

Experience in implementing HPS approaches:		
No or limited experience	Some experience	Extensive experience
Hypothetical examples		
Hypothetical examples The country has no national policy on school health or HPS. A donor-supported project is implemented in two districts with the participation of three primary and three secondary schools.	The country has a national school health policy that has not been reviewed or updated recently. The policy was operationalized in a limited number of districts, with an average of 50% of schools participating in each district.	The country has a national school health policy that was recently reviewed or updated. The policy was operationalized in all districts, but the quality of implementation varies from district to district and from school to school.
Context-specific application of the global guidance		
• Use the global guidance to establish intersectoral government and a multi-stakeholder coordination team to develop a national school health policy aligned with global standards (e.g. national standards for HPS). • Develop a 1–2-year implementation plan aligned with strategic and operational planning cycles of the education sector. • Sensitize all districts and schools to the new policy, and call for expressions of interest from districts and schools to adopt HPS, whether they have experience or not. • Support districts and schools that adopt HPS early with capacity development, including training, operational manuals and tools. • Learn lessons before extending implementation.	• Use the global guidance to review the expired or outdated policy, and develop an updated policy aligned with global standards (e.g. national standards for HPS). • Reinforce intersectoral government and multi-stakeholder coordination. • Sensitize all districts and schools to the updated policy, and support implementation. • Support districts and schools by providing capacity development, including training, operational manuals and tools. • Support prospective learning in districts and schools. • Repeat iterative implementation cycles.	• Use the global guidance to conduct a rapid "gap analysis" of the current policy. • If necessary, develop or update and endorse national standards for HPS, and strengthen accountability by better reporting on indicators and targets. • Consider reinforcing intersectoral government and multi-stakeholder coordination mechanisms in districts. • Support districts and schools by providing capacity development, including training, operational manuals and tools. • Support prospective learning between districts and schools. • Repeat iterative implementation cycles.

Part 2

Implementation areas and strategies

A plan for implementing HPS should be based on the strategies that will be used to implement the eight global standards. In this section, suggested strategies are grouped into 13 implementation areas.

The strategies are mainly sequential, in a staged order, in which one strategy supports implementation of the next. The selection of strategies should be informed by current practices, and the values, needs and priorities of stakeholders, which are described in the implementation cycle referred to under *how*.

Each of the 13 areas is defined in Table 4. All the areas are aligned with the global standards for HPS. Annex 1 provides details of the alignment, the relations among the 13 areas and the level (national, subnational, local or school) responsible for each strategy.

Table 4. Definitions of implementation areas

1
Reinforce intersectoral government and multi-stakeholder coordination.

Facilitate and implement coordination between and within education, health and other government ministries and departments and between and within national, subnational and local government levels to implement sustainable HPS systems in all schools.

2
Develop or update policy.

Develop or strengthen education and health policies to support HPS at national, subnational, local and school levels.

3
Strengthen school leadership and governance practices.

Establish governance for implementation of sustainable HPS systems in schools, in which school leadership plays a key role. The system should include students, civil society organizations and may also include national, subnational and local governments. Development agencies and the private sector may be involved.

4
Allocate resources.

Allocate resources for implementation of all the components of sustainable HPS systems. This may include advocacy and priority-setting for sustaining political support for HPS.

5
Use evidence-informed practices.

Plan and design evidence-informed HPS goals, targets and activities, including the design of implementation plans for using allocated resources, and report progress in monitoring and evaluation systems .

6
Strengthen school and community partnerships.

Develop partnerships and sustained collaborations for implementation of HPS systems within and between national, subnational and local government departments and within and between schools with local organizations and businesses.

7
Invest in school infrastructure.

Develop, improve and maintain school infrastructure, including the physical environment (e.g. facilities and spaces within and around school grounds), as well as policies and practices to support safe, healthy physical and social–emotional environments.

8
Develop the curriculum and associated resources and ensure its implementation.

Develop, review and implement the curriculum (including content and paedagogy) and associated resources (e.g. assessment tools, sample lesson plans, audio-visuals) to promote health and well-being in all subject areas (all scholastic and co-scholastic domains).

9
Ensure access to teacher training and professional learning.

Develop and refine initial teacher training programmes and in-service professional learning to adhere to HPS curricula and associated standards when available. Includes ensuring access to opportunities for participation in continuous professional development and certification by external agencies.

10
Ensure access to comprehensive school health services.

Provide comprehensive school-based or school-linked health services to support health, well-being and educational outcomes for students, their families and the local community.

11
Involve students.

Provide opportunities for children and adolescents (students) to be ethically and meaningfully involved in the inception, planning, implementation (execution) and evaluation of HPS activities in their schools and local communities.

12
Involve parents, caregivers and the local community.

Provide opportunities for parents, caregivers and local community members, including business owners, to be involved ethically (voluntarily) and meaningfully in planning, designing and evaluating HPS activities in schools in their local communities.

13
Monitor and evaluate.

Design, develop and share practices for collecting, storing and analysing data, generating reports, disseminating findings, and adapting HPS systems accordingly including capacity development activities.

Each of the 13 implementation areas is defined and described in the following sections. Examples from the literature and from case studies of whole-school approaches to health in different countries are also provided. The examples illustrate certain barriers and enablers for the implementation areas. Annex 1 provides matrices for mapping the contribution of implementation areas and strategies to each of the eight global standards.

Implementation area 1: Reinforce intersectoral government and multi-stakeholder coordination.

Description: This area reflects all the structures, processes and activities associated with national communication and coordination within and between local and national government departments in key sectors, development partners and United Nations agencies.

The aim of the two strategies for this area (see below and Table A.1 in Annex 1) is to establish and sustain coordination by detailing the structures, roles and responsibilities of an HPS coordination group.

1.1 Identify key stakeholders and roles and responsibilities for HPS in all relevant sectors (education, health and possibly social services, housing, agriculture, employment and culture) and levels of government.

1.2 Establish a multi-stakeholder committee to coordinate policy development and implementation.

1.3. Develop operational structures and plans for collaboration with groups in all relevant sectors and levels of government.

To ensure effective communication:

- include the process for coordination in the plan;
- identify the individuals to be involved;
- describe the decision-making processes;
- reflect whole-of-government in the coordination group; and
- include representatives from all other organizations that should be involved in implementing HPS.

A national policy or strategy for HPS (see implementation area 2) can support coordination by including a rationale for coordination and an approach to identifying stakeholders within and across government and all organizations that should be involved in developing the implementation plan, including HPS targets. The coordination and definition of stakeholders' roles will depend on the country's form of government and on the organizational structures for education and health services. In some countries subnational and local governments may be involved *(38)*.

Source: National Health Promotion Strategic Plan 2015–2023. Thimphu: Ministry of Health, Health Promotion Division; 2015.

Implementation area 2: Develop or update policy.

Description: This area applies to all activities for the development of national, subnational, and local policies or strategies and school policies and plans. Policies and plans should include explicit means to address the priorities in health and well-being that can be addressed by schools, including comprehensive sexuality education, prevention and identification of violence and bullying (particularly sexual and gender-based violence), menstrual health, life skills, nutrition and prevention of risk factors for noncommunicable disease, such as tobacco use and physical inactivity. Establishment of a committee of government and nongovernmental stakeholders to organize national coordination of HPS in all schools in the country is an important part of this area (see implementation strategy 1.2) *(31, 32)*.

Seven implementation strategies are suggested for policy development (see Table A.2 in Annex 1 and below). These reflect the stages of the policy development cycle, including strategies to build on existing education policies for school health and well-being and modify them to align them with the global standards.

2.1 Identify and define health and education needs and how HPS can address them.

2.2 Review existing policies, strategies and plans for school health and well-being.

2.3 Consult stakeholders to inform or update policy.

2.4 Set goals, objectives, targets and working models of HPS in the policy.

2.5 Actively support adoption of the policy through knowledge translation and dissemination.

2.6 Review and evaluate.

Strategies for policy development support other implementation areas. For example, identification of targets for HPS in a national education policy or strategy will support development of implementation area 13 (monitoring and evaluation practices). In countries with a decentralized system for education policy, with a specific jurisdictional or state curriculum or in which assessment and teaching standards apply locally, references to "national" education policy might have to be amended to "national and other jurisdictional" policies *(31, 32)*.

Lessons from evidence

- Recognition of the importance of health in education was the most frequently reported enabler for preparation and planning of implementation of HPS. Embedding HPS in education policy was also more likely when the education and health sectors in a country shared the view that health is part of education, with equivalent importance to learning. Health and well-being are foundations for learning. Recognition within a national education policy that health is inherently connected to academic outcomes can ensure involvement of both the education and the health sector.
- Shared leadership (and distributed leadership) among departments or ministries of education and health ensures the sustainability of HPS. Shared leadership increases the likelihood that a national education policy will include HPS and that collaborative structures will be established between the two sectors.
- International and national expertise in HPS supports policy development. Research, expert advice and thinking leadership will contribute to embedding HPS within national education policies.

Sources: references *31* and *32*

Implementation area 3: Strengthen school leadership and governance practices.

Description: This area addresses a key characteristic of sustainable HPS systems, which is a whole-school approach and a school system of governance for HPS. The four proposed strategies for HPS leadership and governance (see below and Table A.3 in Annex 1) address multi-level leadership and governance. For instance, creation of professional pathways for HPS leadership (including at middle level) will ensure that the governance system for a whole-school approach is institutionalized.

3.1 Define a model of school leadership and governance for implementing HPS that involves students, school and local community members and subnational and national government representatives.

3.2 Identify and document the needs and priorities of students, the school and the local community related to HPS to inform leadership decisions.

3.3. Use inclusive language in all policies and plans, and ensure that all policies and plans for HPS are based on stakeholders' priorities.

3.4 Create professional pathways for HPS leadership, or embed them in existing roles.

The four strategies for implementing this area involve all stakeholders: school staff and local communities, governments, development partners and nongovernmental organizations *(31, 32)*.

Lessons from evidence

- School leaders must be involved in the preparation and planning of HPS implementation to ensure that the needs and context of the local school and community are included in designing HPS. This could include the specific health needs of students in an area and the resources available to respond to those needs. School leaders may include middle leaders (leading teachers, curriculum coordinators) as well as school principals, the governance board or council members.
- Schools must own HPS initiatives, including having control of development and implementation, and flexibility for adoption and delivery. An organizational structure that supports HPS in a school is beneficial for both adoption and collective efficacy, which ensure sustained implementation of whole-school initiatives.

Sources: references *31* and *32*

Implementation area 4: Allocate resources.

Description: Resource allocation is a distinct area that reflects the multiple decision-making processes, advocacy and priority-setting in the provision of resources for all aspects of HPS. The four proposed strategies (see below and Table A.4 in Annex 1) reflect different methods for allocating funds. Each contributes to a national model of flexible funding that can be adapted by decision-makers to changing, locally specific needs and priorities in health and education. Flexible use of funds should be based on guidelines that ensure that resource allocation responds to the characteristics of students (e.g. gender) and include appropriate allocation for the commodities necessary for school health services. Resource-sharing may be an aspect of fund allocation in networks of locally connected schools.

4.1 Review and assess current resource allocations for HPS, including for staff, information and infrastructure.

4.2 Base national HPS budgets on a review of the available resources (human, information, infrastructural, financial), and align the plan with HPS goals and targets.

4.3 Develop a feasible, locally specific model for releasing teacher time for professional learning on HPS.

4.4 Provide opportunities for flexible use of national funds for health promotion in the form of grants and other mechanisms that schools can access according to their needs and contexts.

In the strategy for "teacher relief support", classroom teachers can access professional learning and engage in HPS activities during classroom teaching. The model of "teacher time release and casual relief" may be implemented differently by countries as it depends on the structure of the teaching workforce. Although no specific model is suggested, the model should help to determine the nature and extent of relief support for teachers.

The evidence review *(32)* lists several methods of resource allocation:

- grants or financial awards, which tend to give school leaders autonomy in the use of funds. This is useful for school HPS activities but is insufficient for resource allocation and does not support sustainable HPS *(31)*.
- dedicated funding for HPS implementation from national and local governments;
- dedicated funding for HPS implementation from nongovernmental organizations; and

donations or funding from local community organizations and businesses or private sector organizations (e.g. corporate social responsibility).

Lessons from evidence

- Dedicated funding for HPS implementation in schools (e.g. from national or local government or nongovernmental organizations) is important for the early stages of local policy development and institutional embedding of HPS.
- The capacity of a school to implement HPS requires relational and organizational support, such as provision of time for curriculum planning and implementation. Barriers to implementation include insufficient resources to support staff in leadership and management, lack of staff capacity, lack of staff time and lack of resources to seek external support.
- Access to expertise from external health promotion professionals can support school staff, aid implementation of HPS and facilitate evaluation. Establishment and continuation of support by health professionals in school health services, such as school nurses and counsellors, is essential to the implementation and maintenance of many HPS initiatives.

Sources: references *31* and *32*

Implementation area 5: Use evidence-informed practices.

Description: This area reflects all activities in planning and designing HPS in a school. This should be based on the collection and synthesis of research and evidence and on evidence-based approaches to school implementation, such as communities of practice. Like implementation area 1, this area is the basis for areas 7, 8, 10, 11 and 12.

The five strategies (see below and Table A.5 in Annex 1) provide evidence-informed methods for identifying and designing health promotion activities to address priority areas for capacity development, such as communities of practice.

5.1 Collect and/or synthesize evidence to inform the design of HPS activities in all subnational and school policies and plans, according to their different geographical, cultural, social and economic contexts.

5.2 Establish certification programmes for formal recognition of schools as HPS.

5.3 Commission or fund research and evaluation of national HPS activities and designs that are effective.

5.4 Establish communities of practice or information-sharing networks for school communities and stakeholders (including students, civil society organizations and school health service providers) for sharing data (when appropriate) and experience (e.g. implementation strategies) and providing feedback.

5.5 Develop a logic model for HPS activities; e.g. clarify the relations among goals, objectives, investments, implementation activities, outcomes and impact.

The proposed strategies reflect methods that can be used nationally, sub-nationally or locally to guide schools in making evidence-based decisions in designing school health promotion, such as a national certification or accreditation *(39)*.

Practical lessons from Paraguay

In Paraguay, the healthy school strategy (HSS) (*estrategia escuela saludable*) is a participatory process that accounts for the needs and potential of each school, under the leadership of local, regional and national departments of health and education, with the involvement of other sectors and stakeholders. HSS starts with a situational analysis by school authorities and the school community, including students. An HSS management team is then formed, with representatives of the educational community, the health sector and other community members, such as municipal officials and representatives of public Institutions, the private sector and nongovernmental organizations. A participatory appraisal is conducted, and an action plan is developed for each school. Progress is monitored with indicators defined in the HSS.

For accreditation as a "quality healthy school", the Ministry of Public Health and Social Welfare verifies that the school complies with the criteria and indicators defined in the HSS during a certain period. The criteria suggest that the school could achieve certain results but does not evaluate whether they are achieved. The school decides whether it will operationalize the strategy as a school programme. Certification is formal recognition of the school as a "healthy school" by the WHO Regional Office for the Americas. Currently, 280 schools implement HSS in 18 regions; 88 schools have been accredited, including one indigenous school; and eight schools have been certified as healthy schools. In Misiones, the first region to pilot-test HSS, one school is working towards re-certification.

Paraguay has also prepared a management guide, which includes accreditation and certification indicators. This is reported to have contributed to evolution of HSS in Paraguay during the past 24 years, such that it is now Government policy.

Sources: reference *36*

Implementation area 6: Strengthen school and community partnerships.

Description: This area comprises all activities associated with the establishment, functioning and sustainability of partnerships between schools and communities (e.g. local businesses, health services). As reflected in the global standards for HPS, partnerships are necessary both *within* and *between* stakeholder groups at different levels of governance and in different sectors for a whole-school approach.

The two suggested strategies (see below and Table A.6 in Annex 1) are for the initial work required for structured, transparent establishment of a partnership. This might include a written agreement or plan. The second strategy reflects activities for ensuring that partnerships function well, such as a shared commitment by all parties, opportunities for review and reflection and, at times, improving the functioning of the partnership.

6.1 Formally document partnerships, including roles and responsibilities, resources allocated for partnership activities (e.g. meetings, funds for collaboration) and shared accountability.

6.2 Provide opportunities for all members of the partnership for regular reflection and review of the collaboration to ensure that it remains current and is aligned with the HPS design adopted by the parties.

Examples of partners include faith-based organizations, nongovernmental organizations, local community organizations, local businesses and local health services. The activities of a partnership might include contributing to school governance for HPS (e.g. as a representative on the board) or offering facilities for HPS activities.

Lessons from evidence

- Schools should engage their communities by effective, transparent communication (e.g. making the HPS strategic plan available). They should include parents and caregivers, who might have to be empowered to contribute, especially with senior stakeholders, such as State directors.
- Community partnerships can be facilitated by engagement with external partners in planning and implementation. External partners might include sports and recreational organizations, WHO, local and national governments and local businesses.
- Partnership and collaboration should include local health services (e.g. sexual and reproductive health services) and other services that are already coordinating local initiatives. Implementation could include shared agendas; clear, open communication, with opportunities to meet; interpersonal professional relations among sectors; shared responsibility for embedding health-related curricula into the educational curriculum; and understanding health in education, with the school distributing information about local health services.

Sources: references *31* and *32*

Implementation area 7: Invest in school infrastructure.

Description: This area addresses the development, improvement and maintenance of school infrastructure to ensure a conducive environment for health and well-being. It includes gender-responsive physical facilities (e.g. separate, secure toilets for girls) and the policies and practices for maintaining a healthy physical and social–emotional environment.

The two suggested strategies for this area (see below and Table A.7 in Annex 1) clearly state the requirements for school infrastructure that meet international and national guidelines and standards. Examples include:

- clean water for drinking, hand-washing and toileting; separate, secure toilets for girls; appropriate menstrual health facilities;
- ergonomic desks and chairs;
- access to textbooks and other relevant support for learning (e.g. computers);
- clean classrooms, sports facilities, playgrounds and other outdoor spaces;
- green outdoor spaces protected from direct sunlight;
- appropriate indoor temperature control and access to fresh air;

- a canteen that provides healthy meals and does not provide unhealthy snacks and foods and sugar-sweetened beverages;
- learning resources, libraries and other culturally relevant resources (e.g. musical instruments);
- local (or national where appropriate) support for the contribution of local community members, organizations and businesses to the development and maintenance of school infrastructure;
- safe places immediately outside school grounds to wait for public transport or for local community, parents or caregivers to meet students; and
- commissioning local artists or involving children and adolescents in creating artwork for the school.

7.1 Determine national requirements for school physical and social–emotional environments and infrastructure. These should be aligned with or based on international guidelines, such as for WASH or versatile physical spaces that can be adapted to changing restrictions, as in managing the COVID-19 pandemic.

7.2 Support local government and school leaders in maintaining or investing in infrastructure, with contributions from local community organizations and that are local (e.g. commissioning work from local artists, involving parents, caregivers and students in designing the physical and social–emotional environment).

Like most implementation areas, the development, improvement and maintenance of school infrastructure are essential to the provision of education. Embedding HPS into existing frameworks may leverage more resources and may also enhance the contribution of the school physical and social–emotional environment to health and well-being for staff, students and the community *(31, 32)*.

Lessons from evidence

Infrastructure and facilities that do not support HPS implementation should be identified, such as lack of outdoor green spaces, inadequate space for physical activity, unhealthy school meals, insufficient breaks between lessons, lack of health-related teaching materials or poor-quality facilities. These may be barriers to optimal student health, well-being and learning outcomes.

Sources: references *31* and *32*

Implementation area 8: Develop the curriculum and associated resources and ensure its implementation.

Description: This area refers to development of a curriculum, including its content, assessment and paedagogy, and the resources for promoting health and well-being in *all* subject and content areas. The curriculum should be gender responsive and focus on health and well-being as priorities with the tenets of health promotion, such as life skills and health literacy. While this area refers to promoting health and well-being as part of a whole-school curriculum, including the classroom environment *(40)*, it does not imply that health education is unnecessary. Rather, the intention is to highlight the many ways in which the curriculum can be used. For instance, gender responsiveness could be exemplified in a literature subject by the choice of novels to be read and analysed.

In the same way as for school infrastructure, this area supports implementation of HPS in individual lessons and within and among schools. While it is important to address specific topics in health and well-being, such as comprehensive sexuality education (including menstrual health), prevention of violence and bullying (particularly sexual and gender-based violence), nutrition and risks for noncommunicable diseases (including physical inactivity, tobacco use and unhealthy eating) *(41)*, an intrinsic aspect of HPS is that any curriculum is only one means for addressing these health themes.

To take into account eventual public health emergencies such as COVID-19, the curriculum should be flexible in order rapidly to integrate relevant new content, such as compliance with public health measures to mitigate exposure.

The three suggested strategies (see below and Table A.8 in Annex 1) illustrate the importance of the direct involvement of stakeholder groups beyond the school, such as teacher training institutions (e.g. colleges, universities), national and local governments and all those in a country who define curricula and assessment standards for the education system. In countries with several systems of education (e.g. government, independent), with distinct curricula and assessment standards, HPS should be embedded in all curricula and assessment standards. The involvement of teacher training institutions is particularly beneficial for embedding HPS in the education system.

8.1 Review national and/or other relevant curricula and assessment procedures to identify those to which HPS could be added or strengthened to achieve educational health and well-being.

8.2 Prepare curriculum content and resources (sample assessment tools, template lesson plans, teaching materials and models of school–community collaboration), and make them accessible to teachers and the school community.

8.3 Regularly review the curriculum content and resources to ensure that they are aligned with the dynamic needs, changing priorities and preferences of students, parents, caregivers and the local community and are consistent with international standards for health education and broader well-being.

8.4 Monitor implementation of the curriculum.

Practice lessons from Ireland

In Ireland, the guidelines for well-being in junior cycle *(42)* include well-being as a subject in the secondary school curriculum that is integrated into all other school subjects. Primary school can develop their own well-being programmes, drawing on various curriculum components. The guideline is detailed and includes examples of school well-being programmes and tools for evaluation and assessment.

The Wellbeing policy statement and framework for practice 2018–2023 *(43)* was developed to support curriculum development by defining well-being as an important aspect that should be integrated into every school policy and every part of the curriculum. It sets three goals for promotion of well-being in schools by 2023 and provides indicators of success in four areas: culture and environment, curriculum (teaching and learning), policy and planning, and relationships and partners. The framework also outlines the role of schools, education centres and government in promoting well-being in education. It provides an implementation plan for core aspects, such as the design of well-being promotion, resource allocation, professional development for teachers and a research-based framework for evaluation.

Implementation area 9: Ensure access to teacher training and professional learning.

Description: Activities and processes to equip pre- and in-service teachers to deliver curricula and promote health and well-being during their professional teaching practices are closely related to the development of curricula and associated resources. Both training and continuous professional learning are suggested (see below and Table A.9 in Annex 1). The professional learning requirements of teachers differ by country. For example, some countries finance time for in-service teachers to undertake professional learning (e.g. 20 h pro-rata per year in Scotland); however, *all* teachers and school leaders will require professional learning to implement HPS sustainably. In some countries, professional learning or continuous professional development is organized by nongovernmental agencies, and this model should be included in the requirements for professional learning. The topics covered in professional learning depend on the curriculum and country; however, training should include various topics in health and well-being, including life skills, mental health and sexuality education, promotion of healthy diet and physical activity, and be based on learner-centred paedagogy *(44),* in addition to health education, other health issues, such as approaches to managing the COVID-19 pandemic, should be included.

9.1 Design or commission specific HPS professional learning for in-service teachers.

9.2 Embed school health content and associated paedagogy (e.g. differentiation) for deep learning in pre-service teacher education.

9.3 Incorporate HPS into graduate and in-service teacher standards and registration or certification.

The three proposed strategies cover development of HPS-specific professional learning, which will be useful once the curriculum has been refined and associated resources have been developed. The other strategies relate to the professionalization of teachers and leaders for HPS. This strategy will depend on the teaching workforce and the career pathway structures in countries. When there are professional standards for teachers, HPS should be embedded within them. This would enable countries to support and monitor the professional growth of teachers and leaders to continue to implement and support sustainable HPS systems in their roles at schools *(32, 34).*

Lessons from evidence

- HPS activities can be adapted to fit within various school curricula and reflect different organizational cultures in schools without adding to the already heavy workload of many teachers.
- The status and quality of relational or organizational acknowledgement, support of teachers' workloads and recognition of time limitations are critical to policy reform. Formal school support of teachers' roles in implementing HPS initiatives should consider the difficulties they may have in balancing health and academic priorities in curriculum planning and delivery, especially when their local context does not fully appreciate, recognize or support these activities.
- Teacher professional learning and development that assists teachers in considering the needs and context of the local school and community can promote the uptake of HPS activities.

Sources: references *31* and *32*

Implementation area 10: Ensure access to comprehensive school health services.

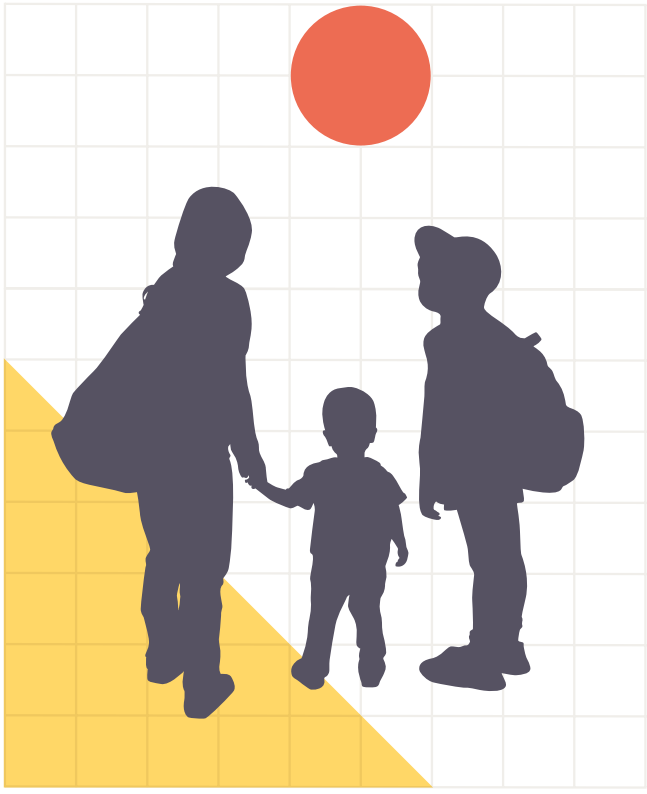
Description: Access to safe, high-quality, age-appropriate, comprehensive school health services that are gender sensitive and respond to the specific needs of students is a component of sustainable HPS systems (e.g. sexual and reproductive health, mental health services, psychosocial support services and promotion of healthy behaviour). The services may either be school-based (physically at the school) or school-linked (e.g. school health services that are provided outside the school premises at facilities or by providers with a formal agreement with the school administration to provide health services to their students or other learners). Comprehensive school health services comprise a range of services in many areas (see box).

What are comprehensive school health services and what types of services are provided?

Comprehensive school health services address the health priorities of the student population in all relevant areas, including: positive health and development, unintentional injury, violence, sexual and reproductive health, including HIV, communicable diseases, noncommunicable diseases, sensory functions, physical disability, oral health, nutrition, physical activity, mental health, substance use and self-harm.

School health services comprise a wide range of services and activities, including health promotion, health education, early detection and screening, preventive interventions (e.g. immunization, mass drug administration), clinical assessment (leading to care and/or referral and support, as appropriate), health services management and support for implementation of other standards of HPS.

The three strategies (see below and Table A.10 in Annex 1) recommended for implementing this area are associated with modifiable aspects of service delivery for HPS. Detailed guidance for comprehensive school health services will shortly become available in a WHO guideline, and see Annex 2 and references *20, 45* and *46*.



10.1 Deliver comprehensive school health services based on a formal agreement between schools (or local education departments) and health service providers. The agreement should explicitly include the provision of equitable funding for all school health personnel, resources for continuous professional education, coordination and information-sharing with other primary care services.

10.2 Deliver comprehensive school health services that are responsive to and aligned with HPS design and activities (e.g. health service staff use messages on health promotion for managing the COVID-19 pandemic that are similar to those used by other school staff).

10.3 Strengthen support for implementation of health services within schools by commissioning research, supporting all school health professionals by ensuring membership of professional associations and providing training or specialization in health topics of relevance to child and adolescent health.

10.4 Strengthen support for students, parents and caregivers to navigate, understand and access school health services .

The suggested strategies are designed to ensure that school health services are mentioned in national and school policies and plans for HPS, so that school health services address priority health and nutritional needs and that the health professionals who provides services and education for members of the school and local community use consistent language and messages on health and well-being. The success of these strategies is ensured by partnerships and collaboration (Implementation area 6), which are also reflected in the characteristics of school-based and school-linked health services, such as described in Indonesia.

Practice lessons from Indonesia

Health services in schools are a critical pillar of the school health programme, *usaha kesehatan sekolah* (UKS). Each primary health centre is a focal point for up to six local public schools. One or two health workers in each primary health centre work consistently with schools, and schools are required to collaborate with the primary health centre health workers in some UKS activities, such as periodic health screening, which includes health check-ups and monitoring of weight and height. Primary health centres are also responsible for providing services in schools, such as deworming and distribution of iodine capsules. The school immunization programme also exemplifies the provision of school-linked health services by primary health centres. The programme is integrated into the UKS infrastructure and provides tetanus boosters as part of the national immunization strategy. In practice, health workers usually work directly with schools without the support of UKS.

Source: reference *36*. See also reference *48*

Implementation area 11: Involve students.

Description: This area refers to all activities, processes and policies associated with creating environments in which children and adolescents feel supported in meaningful participation in planning, designing and evaluating HPS and in wider aspects of school functioning and operations.

Two implementation strategies are suggested (see below and Table A.11 in Annex 1), although there are many ways in which students can be actively involved in their schools, depending on the context of the country. Ideally, students are explicitly involved from the earliest stages of HPS planning and design. Involvement should provide opportunities for students to review and, if necessary, redesign aspects of school functioning and operations, such as the physical environment.

11.1 Create equal opportunities for all students to participate meaningfully in the governance, design, implementation and evaluation of HPS.

11.2 Include students on school councils and governance boards and on HPS design teams, with parents, caregivers and local community members.

Early, meaningful, inclusive involvement of children and adolescents in HPS planning and design and school functioning and operations can give them a sense of ownership of HPS and increase the relevance of HPS activities for the goals and priorities that are important to them and to the wider community. For instance, HPS activities such as engaging in or leading community advocacy (e.g. for hand hygiene) can make them agents of change and ensure meaningful, inclusive involvement.

Irrespective of the nature of HPS, children and adolescents should be involved in evaluation of the activities and, ideally their governance, through student representation on school councils and governance boards and by supporting students to represent their school in local government coordination groups or boards for HPS *(31, 32)*.

Lessons from evidence

- Students should be included in HPS planning, decision-making and implementation in a manner that reflects the diversity of the student body and that is empowering. A culture of inclusion fosters student participation; lack of a culture of inclusion is a barrier to student inclusion and empowerment.
- A positive school culture based on a common purpose can foster belief in the collective efficacy (combined ability of school staff) of the school to implement HPS. A positive school culture is advantageous for whole-school approaches to building and maintaining relational and organizational support for HPS. This ultimately influences the inclusion of students and contributes to health and education outcomes.
- Parent and caregiver support and engagement in school health promotion result in more meaningful collaboration. The inclusion of parents and caregivers in health promotion initiatives can increase their knowledge and that of their children. A sense of belonging to the school community can influence the support of parents and caregivers for participation of their children at school and enhance student health and education outcomes.
- Inclusion of student voices in HPS gives school leaders and staff valuable knowledge about the needs and local context of the school and its community, which allows them to determine how best to fit HPS into that context. Data collected from students, especially when repeated, is also useful for decision-making on resources and funding.

Source: references *31* and *32*

Implementation area 12: Involve parents, caregivers and the local community.

Description: Not only students but parents, caregivers and members of the local community (including civil society organizations and businesses) should also be involved in the design, planning, evaluation and (ideally) the governance of HPS systems. Engagement with local partners should be free of conflict of interests. This area refers to all activities, processes and policies associated with creating environments in which parents, caregivers and members of the local community are supported and enabled to be involved meaningfully in planning, designing and evaluating HPS systems in their schools and local communities (see below and Table A.12 in Annex 1).

12.1 Create opportunities for parents, caregivers and local community members to participate meaningfully in the governance, design, implementation and evaluation of HPS.

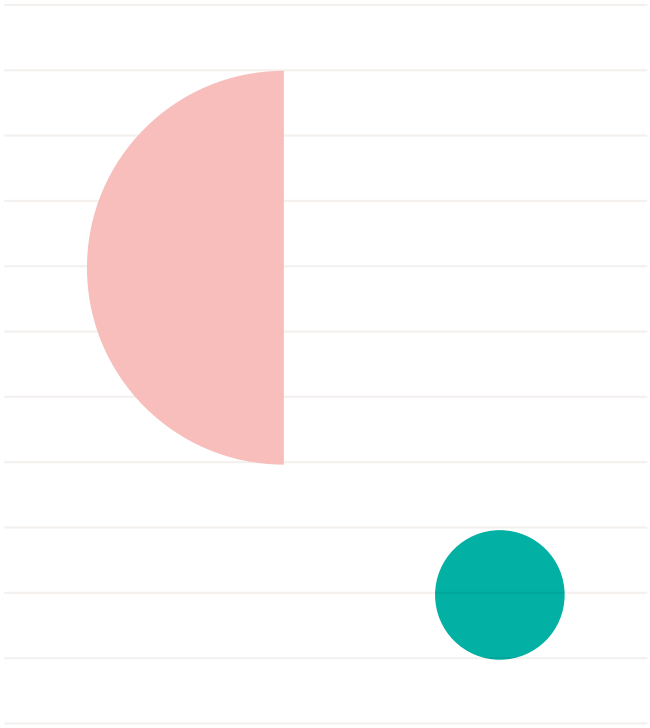
12.2 Include parents, caregivers and representatives of the local community on the school council or governance board and on HPS design teams.

Involving parents, caregivers and the local community (e.g. youth groups, community learning centres that offer informal education for children and adults) provides considerable benefits in planning and designing HPS activities. It also increases the likelihood that parents and caregivers create a healthy home environment for their children as a result of greater awareness and that the local community promotes school-based health and well-being initiatives. This may include widespread acceptance of the importance of access to comprehensive sexuality education and sexual and reproductive health services, promotion of immunization, personal and household hygiene practices and a healthy diet. For instance, while the organizational skills of a local business owner may contribute directly to the planning, design and governance of HPS systems at a school in their community, it may indirectly result in them reviewing their own business policies to promote health and well-being *(49)*.

Practice lessons from Indonesia

The Oplan Kalusugan sa Department of Education is a policy guide on school health and nutrition programmes. Schools are expected to involve parents and community members as partners in implementation of the school health and nutrition programme. In practice, teachers, parents and community members such as local organizations and small business owners, school alumni and even donors, all actively support programme delivery. This is achieved through the school governing board, which is composed of local representatives, teacher representatives and, in some cases, student representatives and alumni. The board represents the community and is responsible for identifying school needs and planning future programmes. In a water and sanitation improvement programme, for instance, parents and the community also participated in constructing washing facilities and providing clean water to schools with difficult access.

Source: reference *36*. and *48*



Implementation area 13: Monitor and evaluate.

Description: The final implementation area is the development of systems for collecting, storing and analysing data from monitoring the implementation and impact of HPS. Development of evaluation capacity is a component of quality practices. Capacity development in this area should be tailored to the learning needs of the stakeholders involved. The suggested implementation strategies reflect three areas of implementation; their scope depends on existing monitoring systems for data on health and education. The strategies pertain to system development rather than monitoring and evaluation. They reflect continuous development, in which a monitoring and evaluation system that facilitates sharing of data and best practices among sectors nationally and even globally is realized progressively (see below and Table A.13 in Annex 1). This could be supported by WHO and UNESCO, which provide standardized tools for collecting data on school health, and also through other web-based monitoring tools.

13.1 Develop coordinated local, subnational and national approaches to sharing data and knowledge from HPS case studies and best practices; develop standardized tools for national monitoring of HPS implementation; and enable international comparisons with appropriate consideration of national contexts and characteristics.

13.2 Provide capacity-building in evaluation (e.g. data collection and analysis) and, when appropriate, training in quality improvement to all those involved in HPS design, planning, implementation and monitoring.

13.3 Invest in feasible (perhaps offline), interoperable systems for collecting and storing data from monitoring at all levels of the education and/or health system (e.g. schools, school health services, local education offices and ministries of education and health).

The monitoring and evaluation system need not be specific to HPS, and it is in fact preferable to use existing systems for monitoring education and health, which could be revised to include monitoring of HPS systems. Monitoring and evaluation are critical to sustainable HPS; ideally, HPS systems should continuously evolve and improve, informed by evidence from monitoring and evaluation *(49)*.

Part 3

Stakeholder analysis and tracking progress in implementation

Practice lessons from Senegal

Since 2000, effective collaboration between the ministries of Health and of Education has supported health promotion in schools. The design, development and implementation of health initiatives for schools are coordinated by the School Medical Control Division of the Ministry of Education, which is also responsible for decisions on health promotion in schools, organized as initiatives or programmes, on many health topics that are not integrated into a whole-school approach. Relevant topics include adolescent sexual health, nutrition education and nutritional supplementation (school canteens are managed by another division), communicable diseases, WASH, neglected tropical diseases and noncommunicable diseases. It includes the development of resources for teachers. Each region has a health focal point, and there are mechanisms for monitoring and reporting. Monitoring is mostly limited to activities on specific health topics, usually as a programme or activity by a nongovernmental organization.

Evaluation of the collaboration revealed several areas for improvement. For instance, implementation of health promotion initiatives in schools is not compulsory and has low uptake, short duration and selective implementation. Another improvement would be to use established networks in the region to incorporate HPS or as models for a Health-promoting school (such as the Ouagadougou Partnership *(50),* a coalition of government officials, religious leaders, civil society members and youth from nine countries, working in collaboration with donors to improve family planning in the region). Establishment of a national forum for consultation on HPS could extend the current focus to include HPS.

Health staff in schools are considered critical in Senegal, and funding for health staff, such as nurses, has been approved by the Division. While the Division acknowledges that health professionals should provide professional development for teachers and sustainable, comprehensive health services, lack of funding remains a barrier to these activities. Global standards for HPS could activate change towards health promotion in schools as part of national strategic planning and systematizing data collection and monitoring.

Sources: references *36* and *50*.

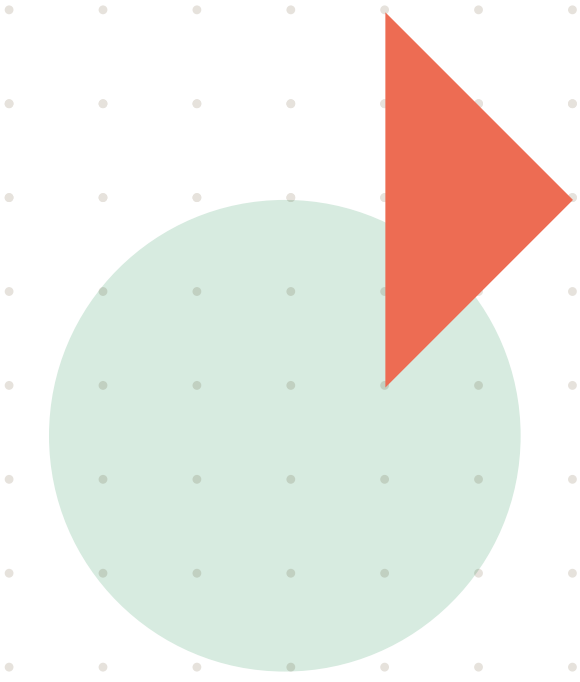
Who?

Stakeholder analysis, implementation progress tracking.

Implementation stakeholders

This implementation guidance for HPS accompanies the global standards and indicators for HPS *(29).* The global standards for HPS provide a vision in which all schools, everywhere, can enhance the health, well-being and educational outcomes of their students and communities. This requires that schools move beyond specific health topics and programmes to embrace a whole-school approach to promoting health and well-being, in which the culture, conditions and curriculum of a school all contribute to an HPS system.

The eight global standards for sustainable HPS systems are listed in Table 1. More information on how the standards were developed is provided in volume 1 *(29)*. The standards are designed to support whole-school approaches to promoting health in educational settings.



Identification of relevant stakeholders is an important part of HPS implementation, which is often a dynamic process. For instance, the involvement of stakeholder groups may be periodic, where some groups have different levels of involvement, depending on which implementation areas are the current focus. The active involvement of senior government leaders may be considerable during the period of policy development (implementation area 2) but may become more consultative once a national education policy and coordination group have been developed. Stakeholders who occupy roles with mandated responsibilities associated with implementing HPS systems, such as reviewing school infrastructure, should be involved more consistently.

Other stakeholders who could be involved periodically can be identified by a stakeholder mapping analysis and from answers to the following questions:

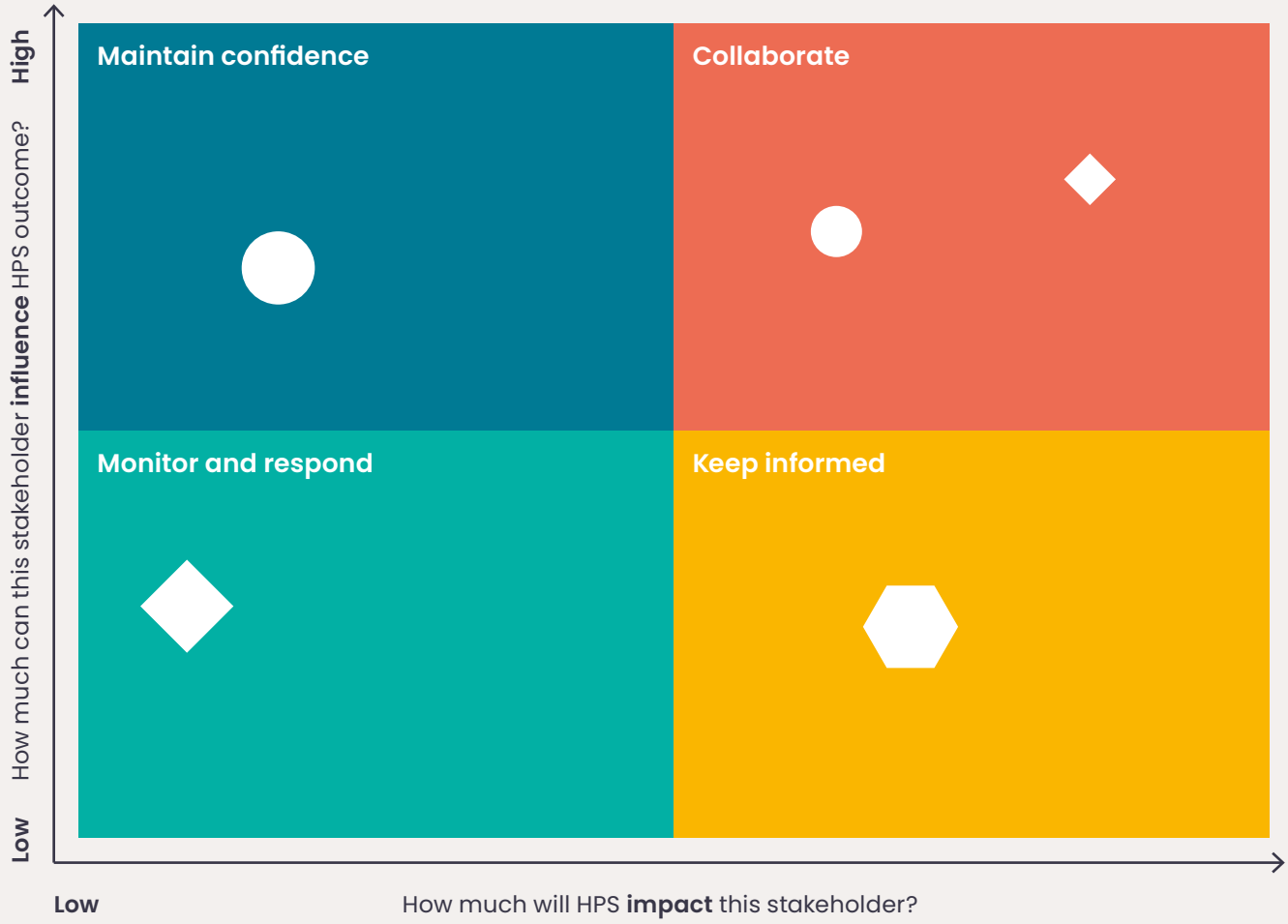
- Who are the main stakeholders in HPS implementation (and how)?
- Who has a direct or indirect influence on planned HPS implementation activities?
- Who is interested in HPS implementation locally, sub-nationally, nationally or internationally?
- Who has experience or can help work towards the goals and targets of HPS implementation?
- Which key stakeholders should be involved in HPS planning?
- Which stakeholders could contribute to HPS implementation through action or inaction?
- Which stakeholders might hinder HPS implementation and why? Who can they influence? How could the hindrance be overcome?
- Who can help in implementing HPS?

Fig. 4 shows the value of using a tool for mapping stakeholder impact and influence in order to analyse the answers to the above questions by stakeholder group to determine the extent to which HPS will impact the group and the degree of influence of the group on the outcomes of HPS activities (shown on the x and y axes, respectively, of the grid in Fig. 4).

Once the impact and influence of the stakeholder group is determined, the type of engagement can be determined (as reflected in each of the four quadrants). For example;

- Stakeholders with strong influence but who are not directly affected by HPS should be addressed with engagement strategies that *maintain confidence* in HPS (e.g. regular information on the progress and impact of implementation) to ensure that they advocate for and promote HPS in their areas of influence (stakeholder group B).
- Stakeholders with strong influence who are directly affected by HPS should collaborate *actively* in implementation of HPS.
- Stakeholders with little influence who are not directly affected by HPS may be *monitored* and, when they demonstrate interest in HPS, may be informed about progress (stakeholder group A).
- Stakeholder groups with little influence who are directly affected by HPS should be *regularly informed and consulted* (stakeholder group C).

Fig. 4. Tool for mapping stakeholder impact and influence*



Adapted from reference *53*

* Individual stakeholders within groups may have different levels of influence

Symbol key

- stakeholder A
- stakeholder B
- stakeholder C

Use of appropriate methods for engaging stakeholders (including documentation) is part of the HPS implementation plan (step 3 of the implementation cycle). Annex 2 provides resources to guide stakeholder analysis, including mapping and tools for selecting engagement methods.

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Annex 1. Implementation areas and global standards

This annex provides matrices for stakeholder analysis and monitoring of implementation progress, aligned with the eight global standards and quality areas. The matrices can be used as checklists, in "Step 2. Analyse the situation", "Step 3. Develop a plan" and "Step 4. Implement and monitor" of the implementation cycle, and to monitor progress in HPS implementation in relation to the global standards. Tables A.1–A.13 can be used as checklists for monitoring progress, illustrating how each of the 13 implementation areas aligns with each of the global standards and with the quality components within each standard.

Table A.1. Implementation area 1: suggested strategies and outputs

Implementation area 1: Reinforce intersectoral government and multi-stakeholder coordination.			
1.1 Identify key stakeholders and roles and responsibilities for HPS in all relevant sectors (education, health and possibly social services, housing, agriculture, employment and culture) and levels of government.	1.2 Establish a multi-stakeholder committee to coordinate policy development and implementation.	1.3. Develop operational structures and plans for collaboration with groups in all relevant sectors and levels of government.	
Level of responsibility (Global, national, subnational, local, school)	**National and subnational**	**National and subnational**	**National, subnational, local, school**
Outputs (quality components)			
1. Government policies and resources			
1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓		
1.2 Leadership of HPS by the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.	✓	✓	✓
1.3 Local government, communities and schools collaborate and have a formal commitment for HPS.	✓		✓
1.4 There are adequate human, information and financial resources to make every school a Health-promoting school.	✓		✓
1.5 There is a system for planning, monitoring of progress and performance and oversight of HPS at national, subnational and local government levels.	✓	✓	✓

Level of responsibility (Global, national, subnational, local, school)			National and subnational	National and subnational	National, subnational, local, school
Outputs (quality components)	**2. School policies and resources**	2.2 The school has a policy and/ or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS.			✓
		2.4 The school regularly plans and monitors implementation and performance of school policies and resources for HPS.			✓
	3. School governance and leadership	3.4 A system ensures regular planning and monitoring of progress and performance of school governance and leadership for HPS.			✓
	6. School socio–emotional environment	6.2 The school has made adequate investment and has adequate resources to promote a safe, supportive social–emotional environment	✓		
	7. School physical environment	7.2 There is adequate investment (e.g. resources, training, funding) to maintain safe school physical and virtual environments.	✓		
	8. School health services	8.1 The delivery of comprehensive school health services is included in school policies and is aligned with national policies and regulations.	✓		
		8.4 Dedicated investment (e.g. resources, training, funding) has been made in school health services, including school nutrition and provision of healthy food.	✓		

Table A.2. Implementation area 2: suggested strategies and outputs

Implementation area 2: Develop or update policy.									
	2.1 Identify and define health and education needs and how HPS can address them.	2.2 Review existing policies, strategies and plans for school health and well-being.	2.3 Consult stakeholders to inform or update policy.	2.4 Set goals, objectives, targets and working models of HPS in the policy.	2.5 Actively support adoption of the policy through knowledge translation and dissemination.	2.6 Review and evaluate.
Level of responsibility (Global, national, subnational, local, school)	All levels	National and subnational	All levels	National and subnational	National, subnational and school	National, subnational and school
Outputs (quality components)						
1. Government policies and resources						
1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓	✓	✓	✓	✓	✓
1.2 Leadership of HPS by the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.		✓	✓	✓	✓	
1.4 There are adequate human, information and financial resources to make every school a health-promoting school.	✓		✓			
1.5 There is a system for planning, monitoring progress and performance and oversight of HPS at national, subnational and local government levels.			✓	✓		✓
2. School policies and resources						
2.1 The school has a policy and/or plan for HPS.		✓	✓	✓	✓	
2.2 The school has a policy and/or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS.			✓		✓	

Level of responsibility (Global, national, subnational, local, school)		All levels	National and subnational	All levels	National and subnational	National, subnational and school	National, subnational and school
Outputs (quality components)							
3. School governance and leadership	3.1 The school leadership team (school board members, management, principal and other school leaders) supports and promotes the value and ethos of HPS for the school community.			✓		✓	
6. School social–emotional environment	6.1 School policies set clear directions for the desired social–emotional environment in the school, including making any necessary improvements and feedback.	✓		✓	✓	✓	
	6.3 The social–emotional environment in the school is monitored regularly, and improvement and feedback actions are taken to ensure a positive environment.						✓
7. School physical environment	7.1 School policies ensure a safe environment for all members of the school community that is aligned with national policy.	✓	✓				
	7.3 Compliance with required standards and regulations for a safe, secure, healthy, inclusive school physical environment is monitored regularly, and corrective actions are taken (e.g. regular checks of equipment).						✓
8. School health services	8.1 The delivery of comprehensive school health services is included in school policies and is aligned with national policies and regulations.	✓	✓				
	8.5 The school has a system for planning and monitoring progress and performance of school health services, including quality assurance and compliance with standards						✓

Table A.3. Implementation area 3: suggested strategies and outputs

			Implementation area 3: Strengthen school leadership and governance practices .			
			3.1 Define a model of school leadership and governance for implementing HPS that involves students, school and local community members and subnational and national government representatives.	3.2 Identify and document the needs and priorities of students, the school and the local community related to HPS to inform leadership decisions.	3.3. Use inclusive language in all policies and plans, and ensure that all policies and plans for HPS are based on stakeholders' priorities.	3.4 Create professional pathways for HPS leadership, or embed them in existing roles.
Level of responsibility (Global, national, subnational, local, school)			**National, subnational, local and school**	**All levels**	**Subnational and school**	**National, subnational, local and school**
Outputs (quality components)	**1. Government policies and resources**	1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓		✓	✓
		1.2 Leadership of HPS by the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.	✓			
		1.3 Local government, communities and schools collaborate and have a formal commitment for HPS.	✓			
	2. School policies and resources	2.1 The school has a policy and/or plan for HPS.	✓		✓	
		2.2 The school has a policy and/ or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS.	✓	✓	✓	

Level of responsibility (Global, national, subnational, local, school)		National, subnational, local and school	All levels	Subnational and school	National, subnational, local and school
Outputs (quality components)					
3. School governance and leadership	3.1 The school leadership team (school board members, management, principal and other school leaders) supports and promotes the value and ethos of HPS for the school community.	✓	✓	✓	✓
	3.2 The school leadership for HPS is distributed and comprises the school principal, leading teachers, administrative staff, members of the school board and management, school health personnel, students, parents and caregivers.	✓	✓		✓
	3.3 HPS leaders (individuals who drive HPS initiatives) are provided with in-service professional learning opportunities in leadership and HPS.	✓			✓
	3.4 A system ensures regular planning and monitoring of progress and performance of school governance and leadership for HPS.	✓			
4: School and community partnerships	4.1 The students, parents, caregivers, legal guardians and families are engaged and collaborate in all aspects of school operations related to HPS.	✓	✓		
	4.2 The school engages and collaborates through formal and informal partnerships with stakeholders in the local community, including local government, for HPS.	✓	✓		
	4.3 Members of the school leadership team collaborate with the school and local communities, including parents and caregivers, in planning and monitoring the progress and performance of HPS partnerships.	✓	✓		

Outputs (quality components)					
5. School curriculum					
5.1 School staff demonstrate knowledge and understanding of the physical, social and psychological development and characteristics of students and how they may affect learning and behaviour.				✓	✓
5.2 The school implements a curriculum that encompasses physical, social–emotional and psychological aspects of student health, safety, nutrition and well-being for key education and health outcomes and is aligned with national HPS policy.			✓	✓	
5.3 The school curriculum fosters understanding, values and attitudes to support sustainable consumption and sustainable environments.			✓	✓	
5.4 The paedagogy and student–teacher and teacher–teacher relationships in the school's curriculum promote health, positive and healthy relationships and lifestyle, safety, physical activity, healthy nutrition and well-being through the development of knowledge, skills, attitudes and behaviour in the school community.			✓	✓	
5.5 Training and support are provided to staff in health literacy and use of learning and teaching strategies to support the HPS approach.		✓	✓	✓	

Outputs (quality components)							
6. School social–emotional environment	6.1 School policies set clear directions for the desired social–emotional environment in the school, including feedback and how to make any necessary improvements.		›		›		
7. School physical environment	7.1 School policies ensure a safe environment for all members of the school community that is aligned with national policy.				›		
8. School health services	8.1 The delivery of comprehensive school health services is included in school policies and is aligned with national policies and regulations.				›		
	8.2 School health services reflect the needs and priorities of the school and local community and can be adapted to public health emergencies and other emerging needs.		›				
	8.3 School health services are delivered according to standards for quality health services for children and adolescents (e.g. timely, culturally safe, sensitive, age-appropriate, gender-responsive, rights-based, evidence-based).		›		›		
	8.4 Dedicated investment (e.g. resources, training, funding) has been made in school health services, including school nutrition and provision of healthy food.						›

Table A.4. Implementation area 4: suggested strategies and outputs

Implementation area 4: Allocate resources.				
4.1 Review and assess current resource allocations for HPS, including for staff, information and infrastructure.	4.2 Base national HPS budgets on a review of the available resources (human, information, infrastructural, financial), and align the plan with HPS goals and targets.	4.3 Develop a feasible, locally specific model for releasing teacher time for professional learning on HPS.	4.4 Provide opportunities for flexible use of national funds for health promotion in the form of grants and other mechanisms that schools can access according to their needs and contexts.	
Level of responsibility (Global, national, subnational, local, school)	**National, subnational and school**	**National, subnational and school**	**National, subnational and school**	**National and subnational**
Outputs (quality components)				
1. Government policies and resources				
1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓	✓	✓	✓
1.3 Local government, communities and schools collaborate and have a formal commitment for HPS.				✓
1.4 There are adequate human, information and financial resources to make every school a health-promoting school.	✓	✓	✓	✓
1.5 There is a system for planning, monitoring progress and performance and oversight of HPS at national, subnational and local government levels.	✓	✓		

Level of responsibility (Global, national, subnational, local, school)			National, subnational and school	National, subnational and school	National, subnational and school	National and subnational
Outputs (quality components)	**2. School policies and resources**	2.3 The school has adequate human, information and financial resources to make progress in becoming a health-promoting school.		✓		✓
		2.4 The school regularly plans and monitors implementation and performance of school policies and resources for HPS.				✓
	3. School governance and leadership	3.3 HPS leaders (individuals who drive HPS initiatives) are provided with in-service professional learning opportunities in leadership and HPS.			✓	
	5. School curriculum	5.5 Training and support are provided for staff in the use of learning and teaching strategies to support the HPS approach.			✓	
	7. School physical environment	7.2 There is adequate investment (e.g. resources, training, funding) to maintain safe school physical and virtual environments.				✓
	8. School health services	8.4 Dedicated investment (e.g. resources, training, funding) has been made in school health services, including school nutrition and provision of healthy food.	✓	✓		✓

Table A.5. Implementation area 5: suggested strategies and outputs

Implementation area 5: Use evidence-informed practices.						
5.1 Collect and/or synthesize evidence to inform the design of HPS activities in all subnational and school policies and plans, according to their different geographical, cultural, social and economic contexts.	5.2 Establish certification programmes for formal recognition of schools as HPS.	5.3 Commission or fund research and evaluation of national HPS activities and designs that are effective.	5.4 Establish communities of practice or information-sharing networks for school communities and stakeholders (including students, civil society organizations and school health service providers) for sharing data (when appropriate) and experience (e.g. implementation strategies) and providing feedback.	5.5 Develop a logic model for HPS activities; e.g. clarify the relations among goals, objectives, investments, implementation activities, outcomes and impact.		
Level of responsibility (Global, national, subnational, local, school)		**Subnational and school**	**Global and national**	**Global, national and subnational**	**All levels**	**Subnational and school**
Outputs (quality components)						
1. Government policies and resources	1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓	✓	✓		
	1.2 Leadership of HPS by the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.			✓		
	1.3 Local government, communities and schools collaborate and have a formal commitment for HPS.	✓	✓		✓	
	1.5 There is a system of planning, monitoring of progress and performance and oversight of HPS at national, subnational and local government levels.	✓	✓			

Level of responsibility (Global, national, subnational, local, school)		Subnational and school	Global and national	Global, national and subnational	All levels	Subnational and school
Outputs (quality components)						
2. School policies and resources	2.1 The school has a policy and/or plan for HPS.		✓			✓
	2.2 The school has a policy and/or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS.				✓	✓
	2.4. The school regularly plans and monitors implementation and performance of school policies and resources for HPS.	✓				✓
3. School governance and leadership	3.2 The school leadership for HPS is distributed and comprises the school principal, leading teachers, administrative staff, members of the school board and management, school health personnel, students, parents and caregivers.	✓			✓	
	3.4 A system ensures regular planning and monitoring of progress and performance of school governance and leadership for HPS.	✓				✓
4. School and community partnerships	4.1 The students, parents, caregivers, legal guardians and families are engaged and collaborate in all aspects of school operations related to HPS.	✓			✓	✓
	4.2 The school engages and collaborates through formal and informal partnerships with stakeholders in the local community, including local government, for HPS.		✓		✓	
	4.3 Members of the school leadership team collaborate with the school and local communities, including parents and caregivers, in planning and monitoring the progress and performance of HPS partnerships.	✓	✓		✓	✓

Outputs (quality components)							
5. School curriculum **5. School curriculum**	5.2 The school implements a curriculum that encompasses physical, social–emotional and psychological aspects of student health, safety, nutrition and well-being for key education and health outcomes and is aligned with national HPS policy.						✓
	5.3 The school curriculum fosters understanding, values and attitudes that support sustainable consumption and sustainable environments.						✓
	5.4 The paedagogy and student–teacher and teacher–teacher relationships in the school's curriculum promote health, positive and healthy relationships and lifestyle, safety, physical activity, healthy nutrition and well-being through the development of knowledge, skills, attitudes and behaviour in the school community.						✓
	5.6 The content and delivery of the school curriculum is regularly planned, monitored for progress and performance and revised (when necessary) to support health and well-being.		✓	✓			
6. School social–emotional environment	6.1 School policies set clear directions for the desired social–emotional environment in the school, including making any necessary improvements and feedback.						✓
	6.3 The social–emotional environment in the school is monitored regularly, and improvement and feedback actions are taken to ensure a positive environment.						✓

Level of responsibility (Global, national, subnational, local, school)		Subnational and school	Global and national	Global, national and subnational	All levels	Subnational and school
Outputs (quality components)						
7. School physical environment	7.1 School policies ensure a safe environment for all members of the school community that is aligned with national policy.					✓
	7.2 There is adequate investment (e.g. resources, training, funding) to maintain safe school physical and virtual environments.		✓			
	7.3 Compliance with required standards and regulations for a safe, secure, healthy, inclusive school physical environment is monitored regularly, and corrective actions are taken (e.g. regular checks of equipment).	✓	✓	✓		✓
8. School health services	8.1 The delivery of comprehensive school health services is included in school policies and is aligned with national policies and regulations.					✓
	8.2 School health services reflect the needs and priorities of the school and local community and can be adapted to public health emergencies and other emerging needs.				✓	✓
	8.3 School health services are delivered according to standards for quality health services for children and adolescents (e.g. timely, culturally safe, sensitive, age-appropriate, gender-responsive, rights-based, evidence-based).			✓		
	8.4 Dedicated investment (e.g. resources, training, funding) has been made in school health services, including school nutrition and provision of healthy food.		✓			
	8.5 The school has a system for planning and monitoring progress and performance of school health services, including quality assurance and compliance with standards.	✓	✓	✓		✓

Table A.6. Implementation area 6: suggested strategies and outputs

			Implementation area 6: Strengthen school and community partnerships.	
			6.1 Formally document partnerships, including roles and responsibilities, resources allocated for partnership activities (e.g. meetings, funds for collaboration) and shared accountability.	6.2 Provide opportunities for all members of the partnership for regular reflection and review of the collaboration to ensure that it remains current and is aligned with the HPS design adopted by the parties.
Level of responsibility (Global, national, subnational, local, school)			**National, subnational and school**	**National, subnational and school**
Outputs (quality components)	**1. Government policies and resources**	1.1 A national education policy or strategy recognizes HPS as a means for achieving national development goals through education and provides a framework for nationwide promotion of HPS.	✓	
		1.2 Leadership of HPS by the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.	✓	
		1.3 Local government, communities and schools collaborate and have a formal commitment for HPS.	✓	
	2. School policies and resources	2.2 The school has a policy and/ or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS.	✓	
	3. School governance and leadership	3.2 The school leadership for HPS is distributed and comprises the school principal, leading teachers, administrative staff, members of the school board and management, school health personnel, students, parents and caregivers.		✓

Level of responsibility (Global, national, subnational, local, school)			National, subnational and school	National, subnational and school
Outputs (quality components)	**3. School governance and leadership**	3.3 HPS leaders (individuals who drive HPS initiatives) are provided with in-service professional learning opportunities in leadership and HPS.		✓
		3.4 A system ensures regular planning and monitoring of progress and performance of school governance and leadership for HPS.		✓
	4. School and community partnerships	4.1 The students, parents, caregivers, legal guardians and families are engaged and collaborate in all aspects of school operations related to HPS.	✓	
		4. 2. The school engages and collaborates through formal and informal partnerships with stakeholders in the local community, including local government, for HPS.	✓	
		4.3 Members of the school leadership team collaborate with the school and local communities, including parents and caregivers, in planning and monitoring the progress and performance of HPS partnerships.	✓	✓
	5. School curriculum	5.4 The paedagogy and student–teacher and teacher–teacher relationships in the school's curriculum promote health, positive and healthy relationships and lifestyle, safety, physical activity, healthy nutrition and well-being through the development of knowledge, skills, attitudes and behaviour in the school community.		✓
	8. School health services	8.2 School health services reflect the needs and priorities of the school and local community and can be adapted to public health emergencies and other emerging needs.	✓	

Table A.7. Implementation area 7: suggested strategies and outputs

Implementation area 7: Invest in school infrastructure.			
7.1 Determine national requirements for school physical and social–emotional environments and infrastructure. These should be aligned with or based on international guidelines, such as for WASH or versatile physical spaces that can be adapted to changing restrictions, as in managing the COVID-19 pandemic.		**Global, national and subnational**	7.2 Support local government and school leaders in maintaining or investing in infrastructure, with contributions from local community organizations and that are local (e.g. commissioning work from local artists, involving parents, caregivers and students in designing the physical and social–emotional environment). **National, subnational and school**
Level of responsibility (Global, national, subnational, local, school)	**Outputs (quality components)**		
	1. Government policies and resources		
	1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓	
	1.2 Leadership of HPS by the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.	✓	
	1.3 Local government, communities and schools collaborate and have a formal commitment for HPS.		✓
	1.4 There are adequate human, information and financial resources to make every school a health-promoting school.	✓	
	1.5 There is a system for planning, monitoring progress and performance and oversight of HPS at national, subnational and local government levels.	✓	

Level of responsibility (Global, national, subnational, local, school)			Global, national and subnational	National, subnational and school
Outputs (quality components)	**2. School policies and resources**	2.1 The school has a policy and/or plan for HPS.		✓
		2.4 The school regularly plans and monitors implementation and performance of school policies and resources for HPS.		✓
	4. School and community partnerships	4.1 The students, parents, caregivers, legal guardians and families are engaged and collaborate in all aspects of school operations related to HPS.		✓
	5. School curriculum	5.1 School staff demonstrate knowledge and understanding of the physical, social and psychological development and characteristics of students and how they may affect learning and behaviour.	✓	✓
		5. The school implements a curriculum that encompasses physical, social–emotional and psychological aspects of student health, safety, nutrition and well-being for key education and health outcomes and is aligned with national HPS policy.	✓	✓

Outputs (quality components)						
6. School socio-emotional environment	6.3 The social–emotional environment in the school is monitored regularly, and improvement and feedback actions are taken to ensure a positive environment.	›				
7. School physical environment	7.1 School policies ensure a safe environment for all members of the school community that is aligned with national policy.	›	›			
	7.2 There is adequate investment (e.g. resources, training, funding) to maintain safe school physical and virtual environments.	›	›			
	7.3 Compliance with required standards and regulations for a safe, secure, healthy, inclusive school physical environment is monitored regularly, and corrective actions are taken (e.g. regular checks of equipment).	›	›			
8. School health services	8.2 School health services reflect the needs and priorities of the school and local community and can be adapted to public health emergencies and other emerging needs.	›				
	8.4 Dedicated investment (e.g. resources, training, funding) has been made in school health services, including school nutrition and provision of healthy food.	›	›			
	8.5 The school has a system for planning and monitoring progress and performance of school health services, including quality assurance and compliance with standards.	›	›			

Table A.8. Implementation area 8: suggested strategies and outputs

Implementation area 8: Develop the curriculum and associated resources, and ensure its implementation.					
8.1 Review national and/or other relevant curricula and assessment procedures to identify those to which HPS could be added or strengthened to achieve educational health and well-being.	8.2 Prepare curriculum content and resources (sample assessment tools, template lesson plans, teaching materials and models of school–community collaboration), and make them accessible to teachers and the school community.	8.3 Regularly review the curriculum content and resources to ensure that they are aligned with the dynamic needs, changing priorities and preferences of students, parents, caregivers and the local community and are consistent with international standards for health education and broader well-being.	8.4 Monitor implementation of the curriculum		
Level of responsibility (Global, national, subnational, local, school)		**National and subnational**	**All levels**	**All levels**	**All levels**
Outputs (quality components)					
1. Government policies and resources	1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓		✓	
	1.3 Local government, communities and schools collaborate and have a formal commitment for HPS.	✓	✓	✓	
	1.4 There are adequate human, information and financial resources to make every school a health-promoting school.		✓		
	1.5 There is a system for planning, monitoring progress and performance and oversight of HPS at national, subnational and local government levels.			✓	✓

Outputs (quality components)						
2. School policies and resources	2.1 The school has a policy and/or plan for HPS.	✓				
	2.2 The school has a policy and/or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS.		✓		✓	
	2.4 The school regularly plans and monitors implementation and performance of school policies and resources for HPS.			✓	✓	✓
3. School governance and leadership	3.1 The school leadership team (school board members, management, principal and other school leaders) supports and promotes the value and ethos of HPS for the school community.		✓		✓	
	3.2 The school leadership for HPS is distributed and comprises the school principal, leading teachers, administrative staff, members of the school board and management, school health personnel, students, parents and caregivers.		✓		✓	
	3.4 A system ensures regular planning and monitoring of progress and performance of school governance and leadership for HPS.				✓	✓

Level of responsibility (Global, national, subnational, local, school)		National and subnational	All levels	All levels	All levels
Outputs (quality components)					
4. School and community partnerships	4.1 The students, parents, caregivers, legal guardians and families are engaged and collaborate in all aspects of school operations related to HPS.		✓	✓	
	4.2 The school engages and collaborates through formal and informal partnerships with stakeholders in the local community, including local government, for HPS.			✓	
	4.3 Members of the school leadership team collaborate with the school and local communities, including parents and caregivers, in planning and monitoring the progress and performance of HPS partnerships.			✓	✓
5. School curriculum	5.1 School staff demonstrate knowledge and understanding of the physical, social and psychological development and characteristics of students and how they may affect learning and behaviour.		✓	✓	
	5.2 The school implements a curriculum that encompasses physical, social–emotional and psychological aspects of student health, safety, nutrition and well-being for key education and health outcomes and is aligned with national HPS policy.	✓	✓		
	5.3 The school curriculum fosters understanding, values and attitudes that support sustainable consumption and sustainable environments.	✓	✓	✓	

Outputs (quality components)							
5. School curriculum	5.4 The paedagogy and student–teacher and teacher–teacher relationships in the school's curriculum promote health, positive and healthy relationships and lifestyle, safety, physical activity, healthy nutrition and well-being through the development of knowledge, skills, attitudes and behaviour in the school community.	✓	✓	✓		✓	
	5.5 Training and support are provided to staff in health literacy and use of learning and teaching strategies to support the HPS approach.	✓	✓				
	5.6 The content and delivery of the school curriculum is regularly planned, monitored for progress and performance and revised (when necessary) to support health and well-being.			✓		✓	
6. School social–emotional environment	6.1 School policies set clear directions for the desired social–emotional environment in the school, including making any necessary improvements and feedback.	✓	✓		✓	✓	
7. School physical environment	7.1 School policies ensure a safe environment for all members of the school community that is aligned with national policy.	✓	✓				
	7.3 Compliance with required standards and regulations for a safe, secure, healthy, inclusive school physical environment is monitored regularly, and corrective actions are taken (e.g. regular checks of equipment).			✓		✓	

Level of responsibility (Global, national, subnational, local, school)		National and subnational	All levels	All levels	All levels
Outputs (quality components)					
8. School health services	8.1 The delivery of comprehensive school health services is included in school policies and is aligned with national policies and regulations.	✓			
	8.2 School health services reflect the needs and priorities of the school and local community and can be adapted to public health emergencies and other emerging needs.			✓	
	8.3 School health services are delivered according to standards for quality health services for children and adolescents (e.g. timely, culturally safe, sensitive, age-appropriate, gender-responsive, rights-based, evidence-based).	✓			✓
	8.5 The school has a system for planning and monitoring progress and performance of school health services, including quality assurance and compliance with standards.			✓	✓

Table A.9. Implementation area 9: suggested strategies and outputs

			Implementation area 9: Ensure access to teacher training and professional learning.		
			9.1 Design or commission specific HPS professional learning for in-service teachers.	9.2 Embed school health content and associated paedagogy (e.g. differentiation) for deep learning in pre-service teacher education.	9.3 Incorporate HPS into graduate and in-service teacher standards and registration or certification.
Level of responsibility (Global, national, subnational, local, school)			**National and subnational**	**Global, national and subnational**	**Global, national and subnational**
Outputs (quality components)	**1. Government policies and resources**	1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓	✓	✓
		1.2 Leadership of HPS by the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.	✓	✓	✓
		1.5 There is a system for planning, monitoring progress and performance and oversight of HPS at national, subnational and local government levels.			✓
	2. School policies and resources	2.1 The school has a policy and/or plan for HPS.			✓

Level of responsibility (Global, national, subnational, local, school)			National and subnational	Global, national and subnational	Global, national and subnational
Outputs (quality components)	**3. School governance and leadership**	3.2 The school leadership for HPS is distributed and comprises the school principal, leading teachers, administrative staff, members of the school board and management, school health personnel, students, parents and caregivers.	✓	✓	
		3.3 HPS leaders (individuals who drive HPS initiatives) are provided with in-service professional learning opportunities in leadership and HPS.	✓		
		3.4 A system ensures regular planning and monitoring of progress and performance of school governance and leadership for HPS.			✓
	5. School curriculum	5.1 School staff demonstrate knowledge and understanding of the physical, social and psychological development and characteristics of students and how they may affect learning and behaviour.	✓	✓	✓
		5.5 Training and support are provided to staff in health literacy and use of learning and teaching strategies to support the HPS approach.	✓	✓	
		5.6 The content and delivery of the school curriculum is regularly planned, monitored for progress and performance and revised (when necessary) to support health and well-being.			✓
	8. School health services	8. 4 Dedicated investment (e.g. resources, training, funding) has been made in school health services, including school nutrition and provision of healthy food.	✓		

Table A.10. Implementation area 10: suggested strategies and outputs

Implementation area 10: Ensure access to comprehensive school health services.				
	10.1 Deliver comprehensive school health services based on a formal agreement between schools (or local education departments) and health service providers. The agreement should explicitly include the provision of equitable funding for all school health personnel, resources for continuous professional education, coordination and information-sharing with other primary care services.	10.2 Deliver comprehensive school health services that are responsive to and aligned with HPS design and activities (e.g. health service staff use messages on health promotion for managing the COVID-19 pandemic that are similar to those used by other school staff).	10.3 Strengthen support for implementation of health services within schools by commissioning research, supporting all school health professionals by ensuring membership of professional associations and providing training or specialization in health topics of relevance to child and adolescent health.	10.4 Strengthen support for students, parents and caregivers to navigate, understand and access school health services.
Level of responsibility (Global, national, subnational, local, school)	**National, subnational and school**	**Subnational and school**	**Global, national and subnational**	
Outputs (quality components)				
1. Government policies and resources				
1.1 A national education policy or strategy recognizes HPS as a means for achieving national development goals through education and provides a framework for nationwide promotion of HPS.	✓	✓	✓	
1.2 The leadership of the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.	✓	✓	✓	
1.4 There are adequate human, information and financial resources to make every school a health-promoting school.	✓		✓	

Level of responsibility (Global, national, subnational, local, school)		National, subnational and school	Subnational and school	Global, national and subnational	
Outputs (quality components)					
2. School policies and resources	2.2 The school has a policy and/or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS	✓		✓	✓
3. School governance and leadership	3.2 There is a distributed model of school leadership for HPS, comprising the school principal, leading teachers, administrative staff, members of the school board and management, school health personnel, students, parents and caregivers.	✓		✓	✓
	3.3 HPS leaders (individuals who drive HPS initiatives) are given opportunities for in-service professional learning in leadership and HPS.	✓		✓	
4. School and community partnerships	4.1 The school engages and collaborates with parents, caregivers, legal guardians and families in all aspects of school operations related to HPS.		✓		✓
	4.2 The school engages and collaborates through formal and informal partnerships with stakeholders in the local community, including local government, for HPS.	✓	✓	✓	
5. School curriculum	5.1 School staff demonstrate knowledge and understanding of the physical, social and psychological development and characteristics of students and how they may affect learning and behaviour.	✓			

Outputs (quality components)							
5. School curriculum	5.4 The content, paedagogy, student–teacher and teacher–teacher relationships in the school curriculum promote health, positive and healthy relationships and lifestyle, safety, physical activity, healthy nutrition and well-being through development of knowledge, skills, attitudes and behaviour in the school community.	›					
8. School health services	8.1 Delivery of comprehensive school health services, including school nutrition and food provision, is included in school policies and aligned with national policies and laws.	›		›	›	›	
	8.2 School health services reflect the needs and priorities of the school and the local community.		›	›	›	›	
	8.3 School health services are delivered according to standards for quality health services for children and adolescents (e.g. timely, culturally safe, sensitive, age-appropriate, gender-responsive, rights-based, evidence-based).	›		›	›	›	
	8.4 There is dedicated investment (e.g. resources, training, funding) in school health services, including school nutrition and food provision.	›			›		
	8.5 There is a system of planning and monitoring of progress and performance of school health services, including quality assurance and compliance with standards.				›		

Table A.11. Implementation area 11: suggested strategies and outputs

Implementation area 11: Involve students.				
		11.1 Create equal opportunities for all students to participate meaningfully in the governance, design, implementation and evaluation of HPS.	11.2 Include students on school councils and governance boards and on HPS design teams, with parents, caregivers and local community members.
Level of responsibility (Global, national, subnational, local, school)		**Subnational and school**	**School**
Outputs (quality components)			
1. Government policies and resources	1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓	✓
2. School policies and resources	2.1 The school has a policy and/or plan for HPS.	✓	✓
	2.2 The school has a policy and/or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS.	✓	✓
3. School governance and leadership	3.1 The school leadership team (school board members, management, principal and other school leaders) supports and promotes the value and ethos of HPS for the school community.	✓	✓
	3.2 The school leadership for HPS is distributed and comprises the school principal, leading teachers, administrative staff, members of the school board and management, school health personnel, students, parents and caregivers.	✓	✓

Outputs (quality components)					
4. School and community	4.1 The students, parents, caregivers, legal guardians and families are engaged and collaborate in all aspects of school operations related to HPS.	›			
	4.2 The school engages and collaborates through formal and informal partnerships with stakeholders in the local community, including local government, for HPS.	›			
5. School curriculum	5.1 School staff demonstrate knowledge and understanding of the physical, social and psychological development and characteristics of students and how they may affect learning and behaviour.	›			
	5.2 The school implements a curriculum that encompasses physical, social–emotional and psychological aspects of student health, safety, nutrition and well-being for key education and health outcomes and is aligned with national HPS policy.	›			
6. School socio-emotional environment	6.3 The social–emotional environment in the school is monitored regularly, and improvement and feedback actions are taken to ensure a positive environment.	›			

Level of responsibility (Global, national, subnational, local, school)			Subnational and school	School
	7. School physical environment	7.3 Compliance with required standards and regulations for a safe, secure, healthy, inclusive school physical environment is monitored regularly, and corrective actions are taken (e.g. regular checks of equipment).	✓	
	8. School health services	8.2 School health services reflect the needs and priorities of the school and local community and can be adapted to public health emergencies and other emerging needs.	✓	
		8.3 School health services are delivered according to standards for quality health services for children and adolescents (e.g. timely, culturally safe, sensitive, age-appropriate, gender-responsive, rights-based, evidence-based).	✓	

Table A.12. Implementation area 12: suggested strategies and outputs

Implementation area 12: Involve parents, caregivers and the local community.				
	12.1 Create opportunities for parents, caregivers and local community members to participate meaningfully in the governance, design, implementation and evaluation of HPS.	**Subnational and school**		
				12.2 Include parents, caregivers and representatives of the local community on the school council or governance board and on HPS design teams. **School**
Level of responsibility (Global, national, subnational, local, school)	**Outputs (quality components)**			
	1. Government policies and resources	1.2 Leadership of HPS by the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.	✓	✓
	2. School policies and resources	1.3 Local government, communities and schools collaborate and have a formal commitment for HPS.	✓	✓
		2.2 The school has a policy and/or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS.	✓	✓
	3. School governance and leadership	3.1 The school leadership team (school board members, management, principal and other school leaders) supports and promotes the value and ethos of HPS for the school community.	✓	✓

Level of responsibility (Global, national, subnational, local, school)		Subnational and school	School
Outputs (quality components)			
3. School governance and leadership	3.2 The school leadership for HPS is distributed and comprises the school principal, leading teachers, administrative staff, members of the school board and management, school health personnel, students, parents and caregivers.	›	›
	3.4 A system ensures regular planning and monitoring of progress and performance of school governance and leadership for HPS.		›
4. School and community partnerships	4.1 The students, parents, caregivers, legal guardians and families are engaged and collaborate in all aspects of school operations related to HPS.	›	›
	4.2 The school engages and collaborates through formal and informal partnerships with stakeholders in the local community, including local government, for HPS.	›	›
	4.3 Members of the school leadership team collaborate with the school and local communities, including parents and caregivers, in planning and monitoring the progress and performance of HPS partnerships.	›	›
8. School health services	8.2 School health services reflect the needs and priorities of the school and local community and can be adapted to public health emergencies and other emerging needs.	›	›

Table A.13. Implementation area 13: suggested strategies and outputs

Implementation area 13: Monitor and evaluate.			
13.1 Develop coordinated local, subnational and national approaches to sharing data and knowledge from HPS case studies and best practices; develop standardized tools for national monitoring of HPS implementation; and enable international comparisons with appropriate consideration of national contexts and characteristics.	13.2 Provide capacity-building in evaluation (e.g. data collection and analysis) and, when appropriate, training in quality improvement to all those involved in HPS design, planning, implementation and monitoring.	13.3 Invest in feasible (perhaps offline), interoperable systems for collecting and storing data from monitoring at all levels of the education and/or health system (e.g. schools, school health services, local education offices and ministries of education and health.)	
Level of responsibility (Global, national, subnational, local, school)	**Global and national**	**Global, national and subnational**	**National and subnational**
Outputs (quality components)			
1. Government policies and resources			
1.1 A national education policy or strategy recognizes HPS as a means to achieve national development goals through education and provides a framework for nationwide promotion of HPS.	✓	✓	✓
1.2 Leadership of HPS by the education sector is established and clearly stated, with continuous support and contributions from health and other sectors at all levels.	✓	✓	✓
1.3 Local government, communities and schools collaborate and have a formal commitment for HPS.			✓
1.5 There is a system for planning, monitoring progress and performance and oversight of HPS at national, subnational and local government levels.	✓		✓

Level of responsibility (Global, national, subnational, local, school)		Global and national	Global, national and subnational	National and subnational
Outputs (quality components)				
2. School policies and resources	2.2 The school has a policy and/or plan for regular engagement, communication and collaboration between the school and stakeholders for HPS.	✓		
	2.4 The school regularly plans and monitors implementation and performance of school policies and resources for HPS.	✓		✓
3. School governance and leadership	3.3 HPS leaders (individuals who drive HPS initiatives) are provided with in-service professional learning opportunities in leadership and HPS.		✓	
	3.4 A system ensures regular planning and monitoring of progress and performance of school governance and leadership for HPS.	✓		✓
4. School and community partnerships	4.3 Members of the school leadership team collaborate with the school and local communities, including parents and caregivers, in planning and monitoring the progress and performance of HPS partnerships.	✓		✓
5. School curriculum	5.5 Training and support are provided to staff in health literacy and use of learning and teaching strategies to support the HPS approach.		✓	
	5.6 The content and delivery of the school curriculum is regularly planned, monitored for progress and performance and revised (when necessary) to support health and well-being.	✓		✓
6. School socio-emotional environment	6.3 The social–emotional environment in the school is monitored regularly, and improvement and feedback actions are taken to ensure a positive environment.			✓

Annex 2. Resource bank

Below is a comprehensive but not exhaustive list of implementation guidance, planning and design resources, school health guidelines and evaluation frameworks that are relevant to HPS implementation. Many resources in this list provide specific details that will complement this document. The resources are grouped according to topic.

Indicators

Barnekow V, Bujis G, Clift S, Jensen BB, Paulus P, Rivett D et al., Health-promoting schools: a resource for developing indicators. Copenhagen: International Planning Committee, European Network of Health Promoting Schools; 2006 (https://www.euro.who.int/__data/assets/pdf_file/0017/240344/E89735.pdf).

Use measures, indicators or metrics. Melbourne: BetterEvaluation; 2020 (https://www.betterevaluation.org/en/plan/describe/measures_indicators).

Developing evaluation indicators. Atlanta (GA): Centers for Disease Control and Prevention; 2020 (https://www.cdc.gov/std/Program/pupestd/Developing%20Evaluation%20Indicators.pdf).

Home-grown school feeding resource framework. Technical document. Rome; Food and Agriculture Organization of the United Nations; 2020 (http://www.fao.org/documents/card/en/c/CA0957EN).

Standards and Indicators. London: National Institute for Health and Care Excellence; 2020 (https://www.nice.org.uk/standards-and-indicators).

Social impact navigator, impact analysis. Berlin: Phineo; 2017 (http://www.social-impact-navigator.org/system/about-us/).

Performance monitoring indicators. Washington DC: US Agency for International Development; 2019 (https://www.usaid.gov/project-starter/program-cycle/cdcs/performance-monitoring-indicators).

Monitoring and evaluation

Developing evaluation questions. Atlanta (GA): Centers for Disease Control and Prevention; 2020 (https://www.cdc.gov/std/Program/pupestd/Developing%20Evaluation%20Questions.pdf).

A framework for program evaluation. Atlanta (GA): Program Performance and Evaluation Office, Centers for Disease Control and prevention; 2017 (https://www.cdc.gov/eval/framework/index.htm).

What is CFIR? Ann Arbor (MI): CFIR Research Team – Center for Clinical Management Research; 2020 (https://cfirguide.org/).

Monitoring and evaluation guidance for school health programs. Focus Resources on Effective School Health (FRESH). Paris: United Nations Educational, Scientific and Cultural Organization; 2014 (https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/FRESH_M&E_THEMATIC_INDICATORS.pdf).

Lopez-Acevedo G, Krause P, Mackay K. Building better policies. The nuts and bolts of monitoring and evaluation systems. Washington DC: World Bank; 2012 (http://documents1.worldbank.org/curated/en/680771468183894133/pdf/681660PUB0EPI004019020120Box367902B.pdf).

Markiewicz A, Patrick I. Developing monitoring and evaluation frameworks. Melbourne: BetterEvaluation; 2016 (https://www.betterevaluation.org/en/resources/guide/developing-monitoring-evaluation-framework-markiewicz-patrick).

Quality standards for development evaluation. Paris: OECD Development Assistance Committee, United Nations Educational, Scientific and Cultural Organization; 2010 (https://www.oecd-ilibrary.org/docserver/9789264083905-en.pdf?expires=1595224678&id=id&accname=guest&checksum=0BA5CDEEFD1908F7CDDFFF6F02346BA8).

Round R, Marshall B Horton K. Planning for effective health promotion evaluation. Melbourne: Victorian Government Department of Human Services; 2005.

Evaluation guidelines. Nairobi: United Nations Development Programme; 2019 (http://web.undp.org/evaluation/guideline/documents/PDF/UNDP_Evaluation_Guidelines.pdf).

Norms and standards for evaluation. New York City (NY): United Nations Evaluation Group; 2016 (http://www.unevaluation.org/document/detail/1914).

USAID educational policy program cycle implementation and operational guidance. Washingon DC: US Agency for International Development; 2020 (https://www.usaid.gov/sites/default/files/documents/1865/USAID_Education_Policy_Program_Cycle_Implementation_and_Operational_Guidance_FINAL.pdf).

HPS planning, design, guidelines and standards

The following resources support the design, planning and implementation of HPS or related health initiatives, including management of the COVID-19 pandemic. They include school health guidelines, evidence of known barriers and enablers to implementation and standards and national guidelines for planning and implementation.

Stakeholder identification, mapping and engagement. AA1000 stakeholder engagement standard. Riyadh: AccountAbility; 2015:17–24 (https://www.accountability.org/standards/_).

School-aged health services. Perth: Child and Adolescent Health Services; 2020 (https://www.cahs.health.wa.gov.au/-/media/HSPs/CAHS/Documents/Community-Health/CHM/School-aged-health-services.pdf?thn=0).

Bada E, Darlington E, Masson J, Santos RM, European standards and indicators for health promoting schools. Haderslev: Schools for Health in Europe Network Foundation; 2019.

A global review of policy, standards and guideline documentation for health promoting schools. Geneva: World Health Organization; 2021.

Parents for healthy schools: A guide for getting parents involved from K–12. Atlanta (GA): Centers for Disease Control and Prevention; 2019.

CHE competencies. Amherst (MA): University of Massachusetts; undated (https://www.umass.edu/sphhs/sites/default/files/CHE%20Competencies.pdf).

Wellbeing policy statement and framework for practice 2018–2023. Dublin: Department of Education and Skills; 2019 (https://planipolis.iiep.unesco.org/sites/planipolis/files/ressources/ireland_wellbeing-policy-statement-and-framework-for-practice-2018-2023.pdf).

Nutrition education in primary schools: a planning guide for curriculum development. Rome: Food and Agriculture Organization of the United Nations; 2010 (http://www.fao.org/3/a0333e/a0333e00.htm).

Gray G, Barnekow VR, Young I. Health-promoting schools: a practical resource for developing effective partnerships in school health, based on the experience of the European Network of Health Promoting schools. Copenhagen: WHO Regional Office for Europe, European Network of Health Promoting Schools; 2006.

Identifying and managing internal and external health knowledge. Gerrards Cross: HealthKnowledge; 2016 (https://www.healthknowledge.org.uk/public-health-textbook/organisation-management/5b-understanding-ofs/managing-internal-external-stakeholders). May be useful for assessing the importance and influence of stakeholders for various components of HPS implementation; contains information on determining whether stakeholders are directly or indirectly involved and mapping them on a power or interest grid.

Identifying stakeholders: key questions. Brussels: Civitas Vanguard; 2009 (https://civitas.eu/sites/default/files/tools_for_stakeholder_analysis_and_participation_-_magda_toth_nagy_rec_.pdf)

Achieving health promoting schools: Guidelines to promote health in schools. France: International Union for Health Promotion Education; 2009.

Ippolito-Shepherd J, Castellanos LM. Strengthening of the health-promoting schools regional initiative: Strategies and lines of action 2003–2012. Washington DC: WHO Regional Office for the Americas; 2003.

Stakeholder analysis. Horsham: Mind Tools; 2016 (https://www.mindtools.com/pages/article/newPPM_07.htm School health guideline_).

School health guideline. Toronto: Ministry of Health and Long-term Care, Population and Public Health Division; 2018 (http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/School_Health_Guideline_2018.pdf).

Zimbabwe school health policy. Harare: Ministry of Primary and Secondary Education, Ministry of Health and Child Care; 2018 (https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/zshp_final_signed_march_2018_reduced.pdf).

Health promotion with schools: A policy for the health system. Sydney: Centre for Population Health; 2000 (https://www.health.nsw.gov.au/heal/Pages/health-promotion-schools.aspx).

Foundations for a healthy school. Toronto: Ontario Ministry for Education; 2014 (http://www.edu.gov.on.ca/eng/parents/healthyschools.html).

O'Connel T, Venkatesh M, Bundy D. Strengthening the education sector response to school health, nutrition and HIV/AIDS in the Caribbean region: A rapid survey of 13 countries. Washington, DC: World Bank; 2009.

Preparing our youth for an inclusive and sustainable world: The OECD PISA global competence framework. Paris: Organization for Economic Co-operation and Development; 2018 (https://www.oecd.org/education/Global-competency-for-an-inclusive-world.pdf).

A systematic review of the enablers and barriers of health promoting schools. Geneva: World Health Organization; 2021.

Safarjan E, Buijs G, Ruiter S. SHE online school manual: 5 steps to a health promoting school. Haderslev: Schools for Health in Europe; 2013 (https://www.schoolsforhealth.org/sites/default/files/editor/How%20to%20be%20a%20health%20promoting%20school/english-online-school-manual.pdf).

Schools (Health Promotion and Nutrition) Scotland Act: Health promotion guidance for local authorities and schools. Edinburgh: Scottish Government; 2008 (https://www.gov.scot/publications/schools-health-promotion-nutrition-scotland-act-health-promotion-guidance-local/).

St Leger L, Young I, Blanchard C. Facilitating dialogue between the health and education sectors to advance school health promotion and education. Paris: International Union for Health Promotion and Education; 2012.

Krick T, Forstater M, Managhan P, Sillanpaa M. The stakeholder engagement manual (Stage 1). Vol. 2. The practitioner's handbook on stakeholder engagement. AccounAbility, United Nations Environment Programme, Stakeholder Research Associates Canada Inc.; 2005:21–40 (https://ccednet-rcdec.ca/sites/ccednet-rcdec.ca/files/the_stakeholder_engagement_manual_-_volume_2.pdf).

SABER – School health. Preliminary assessment of school health policies in the Caribbean Community (CARICOM) and Dominica, Grenada, Guyana, Barbados, St Lucia and St Vincent and the Grenadines. Washington DC: World Bank; 2012 (https://openknowledge.worldbank.org/handle/10986/21544).

UNICEF programme guidance for the second decade: Programming with and for adolescents. New York City (NY): United Nations Children's Fund; 2018 (https://www.unicef.org/media/57336/file).

Comprehensive framework for addressing the school nutrition environment and services. Atlanta (GA): Centers for Disease Control and Prevention; 2019 (https://www.cdc.gov/healthyschools/nutrition/pdf/School_Nutrition_Framework_508tagged.pdf).

Checklist to support schools re-opening and preparation for COVID-19 resurgences or similar public health crises. Geneva: World Health Organization; 2020. Available from: https://www.who.int/publications/i/item/9789240017467

European framework for quality standards in school health services and competences for school health professionals. Copenhagen: WHO Regional Office for Europe; 2014.

Global accelerated action for the health of adolescents (AA-HA!), guidance to support country implementation. Geneva: World Health Organization; 2017.

Guideline on school health services. Geneva: World Health Organization; 2021.

Life skills education school handbook – noncommunicable diseases: Approaches for schools. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240005020).

WHO, UNAIDS. Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents. Vol. 1: Standards and criteria. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/handle/10665/183935).

WHO, UNAIDS. Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents. Vol. 2: Implementation guide. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/183935/9789241549332_vol2_eng.pdf?sequence=4).

WHO, UNAIDS. Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents. Vol. 3: Tools to conduct quality and coverage measurement surveys to collect data about compliance with the global standards. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/183935/9789241549332_vol3_eng.pdf?sequence=5).

Health promoting schools; experiences from the Western Pacific Region. Manila: WHO Regional Office for the Western Pacific; 2017.

Consultation on health-promoting schools in the Eastern Mediterranean Region. Cairo: WHO Regional Office for the Eastern Mediterranean; 2005.

Cost-effective approaches to improve global learning: What does recent evidence tell us are "smart buys" for improving learning in low- and middle-income countries? Washington DC: World Bank; 2020 (http://documents1.worldbank.org/curated/en/719211603835247448/pdf/Cost-Effective-Approaches-to-Improve-Global-Learning-What-Does-Recent-Evidence-Tell-Us-Are-Smart-Buys-for-Improving-Learning-in-Low-and-Middle-Income-Countries.pdf).

Assessment tools

An assessment tool to conduct "gap analysis" against global standards for health-promoting schools.

School health profiles. Atlanta (GA): Centers for Disease Control and Prevention; 2020 (https://www.cdc.gov/healthyyouth/data/profiles/index.htm).

Physical education curriculum analysis tool. Atlanta (GA): Centers for Disease Control and Prevention; 2019 (https://www.cdc.gov/healthyschools/pecat/index.htm).

Health education curriculum analysis tool (HECAT). Atlanta (GA): Centers for Disease Control and Prevention; 2019 (https://www.cdc.gov/healthyyouth/hecat/index.htm).

School health index: A self-assessment and planning guide e-learning module. Atlanta (GA): Centers for Disease Control and Prevention; 2018 (https://www.cdc.gov/healthyschools/professional_development/e-learning/shi.html).

Rapid assessment and action planning process. Geneva: World Health Organization; 2020 (https://www.who.int/school_youth_health/assessment/raapp/en/).

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