



# Situation Analysis Report

Health Promoting Schools (HPS) Programme in Bangladesh



**Directorate of Secondary and Higher Education (DSHE)**

**Secondary and Higher Education Division**

**Ministry of Education, Dhaka-1205,**

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**Report design: Ms. Gazi Fabiha Noshin Meem, Program Assistant - Education, UNESCO Dhaka Office, Bangladesh**

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# **Situation Analysis Report**

Implemented by: Directorate of Secondary and Higher Education (DSHE)

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## The Contributors

### Technical Advisory Team: (DSHE & UNESCO)

#### Directorate of Secondary and Higher Education (DSHE)

- Professor Dr. Khan Moinuddin Al Mahmud Sobel, Director General, DSHE, Bangladesh
- Professor Dr. Mir Zahida Naznin, Director, Planning and Development, DSHE, Bangladesh
- Nahida Parvin, Deputy Director, Research & Innovation, DSHE, Bangladesh
- Md. Mizanur Rahman, Assistant Director, Planning and Development, DSHE, Bangladesh
- Mr. Jeshan Ahmed, Research Officer, Planning and Development, DSHE, Bangladesh

#### UNESCO

- Dr. Susan Vize, Head of Office and UNESCO Representative to Bangladesh
- Ms. Jenelle Babb, Regional Advisor, Education for Health and Well-being, Education Section, UNESCO Regional Office in Bangkok
- Mr. Norihide Furukawa, Head of Education, UNESCO Dhaka Office, Bangladesh
- Ms. Sarita Jadav, National Project Officer, HIV & AIDS Education, UNESCO New Delhi, India
- Mr. Raju Das, Programme Officer, UNESCO Dhaka Office, Bangladesh
- Mr. Worapot Yodpet, Associate Project Officer, UNESCO Regional Office in Bangkok

### Research Team:

- Prof. Nazmul Haq, Former Professor of Education, IER, Dhaka University
- Dr. Kaosar Afsana, Professor, James P Grant School of Public Health (JPGSPH), BRAC University
- Dr. Saira Hossain, Associate Professor, IER, Dhaka University
- Dr. Syed Tanveer Rahman, Associate Professor, Department of Psychology, Dhaka University
- Ms. Atiya Rahman, Assistant Scientist, BRAC James P Grant School of Public Health, BRAC University

### Proofread:

- Dr. Miao Md. Naushaad Kabir, Associate Professor and Former Head, Department of English Language, Institute of Modern Languages, University of Dhaka

## List of Abbreviations

|         |                                                                  |
|---------|------------------------------------------------------------------|
| ANESH   | Assessment of National Education Systems for Health              |
| BANBEIS | Bangladesh Bureau of Educational Statistics                      |
| CPD     | Continuous Professional Development                              |
| DEO     | District Education Officer                                       |
| DSHE    | Directorate of Secondary and Higher Education                    |
| ERD     | Economic Relationship Division                                   |
| FGD     | Focus Group Discussion                                           |
| HPS     | Health-Promoting Schools                                         |
| INEE    | Inter-Agency Network for Education in Emergencies                |
| IPA     | Implementation Partners Agreement                                |
| KAP     | Knowledge Attitude and Practice                                  |
| KIi     | Key Informant Interview                                          |
| MoE     | Ministry of Education                                            |
| M&E     | Monitoring and Evaluation                                        |
| MPO     | Monthly Pay Order                                                |
| NCTB    | National Curriculum and Textbook Board                           |
| NGO     | Non-Governmental Organization                                    |
| PTA     | Parent-Teacher Association                                       |
| SDG     | Sustainable Development Goal                                     |
| SRHR    | Sexual and Reproductive Health Rights                            |
| TAC     | Technical Advisory Committee                                     |
| TNA     | Training Needs Assessment                                        |
| UN      | United Nation                                                    |
| UNAIDS  | Joint United Nations Programme on HIV and AIDS                   |
| UNESCO  | United Nations Educational, Scientific and Cultural Organization |
| UNFPA   | United Nations Population Fund                                   |
| UNICEF  | United Nations Children's Fund                                   |
| USEO    | Upazila Secondary Education Officer                              |
| WFP     | World Food Program                                               |
| WHO     | World Health Organization                                        |

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## Foreword

It is with immense pleasure that we present this Situation Analysis on Health-Promoting Schools (HPS) in Bangladesh. This timely study serves not merely as a diagnostic tool but as a foundational document that anchors our national education priorities within the global mandate for creating nurturing, resilient, and inclusive learning environments for every child.

The findings contained herein reinforce the necessity of adopting a whole-of-school approach to well-being. True educational transformation transcends curriculum delivery; it requires a systemic commitment where the physical, mental, and social health of both learners and educators is non-negotiable. This holistic model is manifested through four interconnected pillars: robust policies that support healthy behaviors; dynamic classroom practices that integrate health literacy; a positive school culture built on safety and inclusion; and meaningful community engagement that extends the health ethos into families and surrounding environments. This comprehensive strategy ensures that every school becomes a place where students can truly thrive, not just survive.

Crucially, this Situation Analysis is firmly rooted in the shared global vision for education, reflecting international consensus on the centrality of learners' well-being and enabling learning environments. The approach detailed in this study directly addresses and is strengthened by the following landmark agreements:

- **SDG 4-Education 2030:** Our work is committed to fulfilling the promise of quality education for all, particularly aligning with Target 4.7 (on education for sustainable development and global citizenship) and Target 4. a (on building and upgrading inclusive, safe, and effective learning environments).
- **The Transforming Education Summit (TES) Outcome Document and Foundational Learning:** This study echoes the urgency of the TES Action Track 1 on *Inclusive, Equitable, Safe and Healthy Schools*. By prioritizing health and well-being, we enable the acquisition of foundational literacy and numeracy, the essential building blocks articulated in the Call to Action on Foundational Learning.
- **The Bangkok Statement of APREMC II (2022):** As part of the Asia-Pacific community, we reaffirm the call for educational recovery and transformation, recognizing that ensuring the health and well-being of learners is paramount to achieving learning continuity and building resilient education systems against future shocks.
- **The 2023 Recommendation on Education for Peace, Human Rights and Sustainable Development:** The HPS framework provides the concrete mechanisms for implementing this recommendation by empowering learners with the socio-emotional skills, values, and attitudes required to build peaceful, just, and healthy societies.
- **The Fortaleza Statement of the Global Education Meeting 2024:** This most recent declaration underscores that investing in education is a strategic long-term investment and a critical enabler for improved health outcomes. The findings from Bangladesh contribute directly to the global movement for enhanced multi-sectoral collaboration and dedicated financing for inclusive education.

We are confident that the evidence and recommendations contained within this Situation Analysis will serve as an invaluable resource for policymakers, school administrators, educators, and community partners in Bangladesh. By embracing the whole-of-school approach, we can collectively transform our education landscape, ensuring that health and learning mutually reinforce each other to build a brighter, more sustainable future for the next generation.

## Executive Summary

This study aimed to analyze the situation of health and well-being education in secondary schools in Bangladesh, considering global Health Promoting Schools (HPS) standards and indicators. The UNESCO-WHO HPS framework provides a holistic, whole-of-school approach to health promotion across eight key areas. Implementation of this framework in Bangladesh is often fragmented and focused narrowly, overlooking critical aspects like comprehensive health and well-being education and nutrition. A truly effective HPS approach demands consistent application of whole-of-school strategies where various components like teachers' support and training, student well-being and development, parent/caregiver engagement, school governance, and policy are deeply interconnected.

The findings from the Training Needs Assessment (TNA) provides the recommendation for the systemic changes that are required. A systemic intervention would be integrating hygiene education into the curriculum, providing continuous supplies for hand washing stations, and establishing a student-led hygiene monitoring committee, thus linking Curriculum, School Environment, and Student Well-being.

Using a Convergent Mixed-Methods Design, the research collected quantitative data from approximately 458 students (58.3% female) and 206 teachers (35% female), along with qualitative insights from Focus Group Discussions (FGDs), Key Informant Interviews (KIs), and document reviews.

This comprehensive approach ensured a thorough understanding of health and well-being-related policies, curricula, services, environments, governance, and community partnerships align with Global HPS Standards.

The quantitative data for the situational analysis of Health Promoting Schools (HPS) in Bangladesh were obtained from 48 schools and analyzed comprehensively. This dataset included responses from 458 students (58.3% girls) and 206 teachers (35.9% female) across eight divisions of Bangladesh. Additionally, qualitative data were gathered from 24 focus group discussions (FGDs), which were evenly distributed among teachers, students, parents, and other community members. Furthermore, 12 key informant interviews (KIs) were conducted with head teachers, education officers, health officers, and curriculum experts. The findings reveal critical disparities and systemic weaknesses across the eight HPS domains, particularly in policy awareness, infrastructure provision, and dedicated health training.

The study reveals a significant gap between students' formal knowledge and their daily practice of healthy behaviors:

- **Knowledge gap:** As per knowledge survey checklist (covering health, nutrition, environment, drug addiction, gender discrimination, etc.), students demonstrated poor knowledge, scoring an average of 12.8 (boys: 13.27, girls: 12.46) out of 30 full score. This low score was consistent across all academic grades.
- **Attitudinal level:** Students maintained a moderate level of positive attitude towards health and well-being of life, with a mean of 50.46 out of a maximum 66 score, of which the boys' mean score is 50.71, and the girls' mean score is 50.29.
- **Measures of practice level:** Despite low knowledge, students showed a significantly high position in healthy practice. Their mean score is 24 out of 30 (boys' is 24.16 and girls' is 24.02). Gender and class variations in practice level among students were minimal.

While the teaching population is generally well-qualified (approximately three-fourths hold Master's and B.Ed. degrees), their specific training in health education is critically low:

- **Health-related training:** Only about 30.1% of all teachers reported receiving any training on health education or students' well-being. This figure was lower for government schoolteachers (22.5%) and rural schoolteachers (18.2%) compared to 34.7% and 35.9%, respectively for non-government and urban school teachers. However, these findings largely support TNA results in many respects, particularly in the field of student well-being.
- **Duration of training:** Of those trained, a significant majority (74.2%) received training lasting only 1-2 days. However, fewer of them received training over two days.
- **Policy disconnects:** A significant portion of teachers (61.2%) wrongly believed that a standalone Health Education Policy exists, and many remain unaware of the health components within the comprehensive National Education Policy (NEP 2010), highlighting a failure in policy dissemination.
- **Neglect of health subjects:** Subjects like Health and Hygiene are largely neglected, mainly due to their exclusion from the final examination. However, only 8.2% of teachers reported that they taught them.

Students consistently perceived a notable disparity in the physical environment and health support between school types:

- **Non-government schools superior:** Non-government schools were consistently rated higher for having superior facilities, including cleaner toilets (57.7% vs. 36.02% in government schools), pollution-free environments, and safer drinking water.
- **Lack of dedicated health support:** Access to dedicated, separate health workers for emergency support was minimal, reported by only 7.58% of government school students compared to 28.03% of non-government school students.
- **Poor health service provision:** Overall health service provision is low: only 33.6% reported regular health checkups, and 43% reported emergency arrangements for accidents.
- **Diversity inclusion gap:** While religious tolerance is high, a concerning lack of acceptance for children with disabilities (though only mental disabilities (or cognitive/psychosocial) disabilities were accepted) was reported in a substantial majority of schools, a view corroborated by teachers, with only 20.9% reporting positive psycho-social rules ensuring the inclusiveness of diverse abilities.
- **Integrated teaching is spontaneous:** While formal health education is limited, a substantial majority of teachers (especially in non-government schools) spontaneously integrate health topics (hand washing, balanced diet, conflict resolution) into other subject lessons.
- **Parental reliance:** Student healthcare overwhelmingly relies on the family, with 92.8% of students reporting parents encourage health practices at home.
- **Limited school campaigns:** School involvement in public health campaigns is limited, though immunization programmes show high participation (79.3%). However, campaigns on non-communicable diseases (26.2%) and adolescent/drug addiction (23.0%) are infrequent.
- **Lack of coordination at the ministerial level:** There is a perceived coordination lack between the three Ministries (Education, Health, and Social Well-being) responsible for individual tasks, having their own agenda of SOP. This separation in management and organization hampers effective policy implementation, often leaving the sole responsibility for health improvement to the schools.
- **Lack in implementation phases:** National policies often fail to reach the grassroots level effectively, resulting in unawareness among on-the-ground staff and implementing agencies. This forces schools to resort to "alternative methods" to carry out government orders due to the lack of inter-departmental coordination and allocation of necessary funds for essential activities (e.g., cleanliness).

There is a notable difference in the implementation of health and education systems based on school governance. These are:

- Private schools are often comparatively better than government schools in terms of their institutional arrangement and opportunity of hiring necessary service staff on ad hoc basis, which the government school cannot do (World Bank SABER Report 2016).
- This is attributed to the greater decision-making freedom of the private school headmaster and their ability to collaborate with parents and local communities, which government schools are often restricted from doing by strict financial policies.

Despite being a separate subject or included in other textbooks, there are critical gaps in the curriculum and its delivery, such as:

- **Curriculum Coverage:** The coverage of important health topics is not up to the mark and is found incomplete in many places.
- **Omitted Topics:** Key issues like road safety, drug addiction, suicide prevention, children's sanitary health, emergency procedures, environmental health, and do-it-yourself health practices are often overlooked.
- **Non-Examination Status:** Health education, which is not included in examinations, reduces its perceived importance. Including Health Education in the official examination system makes it a high-stakes subject, compelling all parties- students, teachers, and the school to treat it with greater academic seriousness.
- **Staffing:** There is a significant lack of physical education (PE) teachers in most institutions. Generally, male teachers are recruited for boys' and co-education school while the appointment of female PE teacher is mandatory for girls' schools. World Bank data shows that only 28.7% of the PE teachers in secondary schools are female (Gender Data Portal World Bank 2024).



## Recommendations

Here are some abridged recommendations derived from the study (details are given in the Discussion chapter).

### 1. Strengthen Inter-Ministerial Coordination & Policy

- **Establish a multi-sectoral coordination mechanism:** It is necessary to establish a formal, high-level coordination committee among the Ministries of Education, Health, and Social Welfare to integrate health promotion as a shared responsibility and end the current lack of coordination.
- **Reform SOPs and dissemination:** There is a problem with the current operational procedure; it is necessary to review and reform Ministerial Standard Operating Procedures (SOPs) to support integration and implement mandatory training to ensure national policies effectively reach grassroots implementers (schools/field staff).

### 2. Enhance School Governance and Leadership

- **Increase autonomy for government school headmasters:** Plan to provide greater decision-making freedom and financial flexibility to headmasters in government schools to enable effective health and development initiatives.
- **Mandate and empower school managing committees (SMCs):** Create facilities to ensure SMCs are active, trained, and effectively engaged in overseeing student health and allocating necessary funds for it.
- **Foster school-community partnership:** Encourage and support all schools, especially government ones, to collaborate with parents, local communities, and health workers for student well-being.
- **Supportive supervision:** Provisions need to be created for supportive supervision and mentoring for the well-being of teachers and students in terms of their physical, mental and socio-emotional issues.
- **Partnership:** To run the school health activities, every school should establish a local partnership with the community, law enforcement agencies and local health clinics.

### 3. Improve Health Services and Environment

- **Establish physical, mental and social environment:** Ensure all physical facilities in the school are supportive of the physical and mental health and well-being of the students.
- **Establish all kinds of physical and socio-emotional health services in the school:** Establish comprehensive physical and socio-emotional health services in all schools, ensuring the immediate availability of primary healthcare. These services should be managed and delivered under the direct supervision of a qualified, trained medical professional.
- **Mandate staff training and counseling:** Provide mandatory first-aid training for sufficient staff in every school and allocate resources to appoint trained counselors or guidance teachers to address mental health gaps.
- **Introduce mid-day meals and improve sanitation:** Launch a mid-day meal program for nutritious food access. Allocate funds to drastically improve the physical environment, sanitation, and wash facilities, including disposal systems for sanitary napkins.
- **Stop consumption of unhealthy food:** It is necessary to monitor and stop all kinds of unhealthy food intake obtained from within and outside school premises.

#### **4. Socio-emotional environment and physical activity**

- **Prioritize continuous physical activity:** Restructure the class schedule and school activities to allow for necessary time for play and outdoor physical movements throughout the week, beyond the initial assembly and one-time annual events. These physical activities should be linked to life-skills objectives such as resilience, teamwork and self-regulation. This is to enhance the socio-emotional well-being of students.
- **Address the shortage of physical education (PE) staff and equipment:** Ensure the appointment of qualified physical education teachers in all schools. Furthermore, allocate funds for and make sports equipment accessible to students for regular use, rather than keeping it in storage.
- **Tackle psychosocial issues:** Schools should actively work to protect all students from teasing, bullying, and mental harassment by building social connections with external agencies and providing effective supervision. More so, Parents and caregivers' awareness and engagement programmes should be conducted regularly to establish understanding of adolescent mental health needs, early signs of distress, and healthy parenting practices.

#### **4. Reform Curriculum and Physical Activity**

- **Rigorously revise health education curriculum:** Conduct a thoughtful and rigorous adjustment of the secondary curriculum and textbooks, ensuring quality, depth, and alignment with established health principles (e.g., WHO).
- **Integrate critical topics:** Explicitly include often overlooked subjects like road safety, drug addiction, suicide prevention, emergency practices, and children's sanitary health.
- **Prioritize continuous physical activity and staffing:** Restructure class schedules to allow time for regular play and outdoor movement. Ensure the appointment of qualified Physical Education (PE) teachers in all schools and make sports equipment accessible.
- **Establish a monitoring and evaluation mechanism:** Appoint a dedicated, multi-stakeholder HPS Monitoring Committee (or Working Group), including students, teachers, administrators, health professionals, and parent representatives, to oversee and execute all M&E activities.

#### **5. Ensure Adequate Resource Allocation**

- **Allocate dedicated and specific funding:** Crucially, the relevant Ministries must plan, integrate into the policies, training plans, and operational plans, and allocate adequate and specific funding for the establishment and continuous operation of Health Promoting Schools, covering infrastructure, staffing, training, and services.

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# Chapter 1

## Introduction

### 1.1 Background and Context of the Study

The Health Promoting School (HPS) framework, originally established by the World Health Organization (WHO, 1986), represents a comprehensive, whole-school approach to health and well-being. It is defined as a school that constantly works to improve the health status of its students, staff, and surrounding community, viewing the school as a strategic setting for living, learning, and working (WHO, 1986, 2021). The HPS model extends beyond traditional health education to integrate health promotion across eight key domains: national and school policies, physical and social environments, curriculum, health services, governance, and community partnerships (Islam and Banna, 2020). This study determines the existence of those domains in the present structure of secondary school in Bangladesh.

The foundation of the Health Promoting School (HPS) initiative is firmly established within the nation's commitment to achieving Sustainable Development Goal 4 (Quality Education), with the Ministry of Education designating the HPS framework as a priority strategy for school-based health and wellness. This commitment is further reinforced by regional calls to action like strengthened primary health care (PHC under Colombo Declaration on Healthy Ageing 2025) which urges member states to adopt comprehensive, whole-of-school approaches to health as a key method for tackling rising rates of non-communicable diseases and improving mental well-being across the region. Consequently, the HPS directly addresses several practical government needs, including the requirement for cost-effective and sustainable preventative health measures. It serves as an essential delivery mechanism to integrate health services, educational curricula, and community participation, ultimately ensuring that resources are utilized efficiently to mitigate public health risks and improve student attendance and educational attainment.

Only healthy school environments can nurture students who are ready to learn, thus directly enhancing educational outcomes. As a strategic platform, the HPS is crucial for delivering preventive and primary healthcare services and for shaping lifelong healthy behaviours among children and adolescents, who represent a pivotal segment of any nation's future generation.

### 1.2 The Problem in the National Context

Bangladesh faces a dual burden of public health challenges, including persistent infectious diseases, widespread nutritional deficiencies, and a rapidly increasing prevalence of non-communicable diseases (NCDs). The WHO's HPS model offers a promising, early-stage intervention framework for mitigating these complex health issues.

Despite the compelling potential of HPS, its implementation at the secondary school level in Bangladesh is currently suboptimal and fragmented. The concept remains an **incomplete idea** among many secondary school administrators and teachers, often being narrowly interpreted as basic hygiene rather than holistic well-being (NAEM TNA Study Report, 2024). Specifically, crucial areas like **mental health, physical activity, nutritional awareness, and reproductive health education** are frequently neglected in favour of traditional sanitation practices.

Significant systemic challenges include:

1. **Limited Resources and Infrastructure:** Insufficient funding, lack of necessary facilities (e.g., inadequate playgrounds, poor WASH facilities), and minimum recruitment of specialized teachers (e.g., Physical Education teachers).
2. **Implementation Gaps:** Academic pressure often minimizes time for physical and psycho-social activities. Moreover, schools are often not concerned with maintaining a safe socio-emotional environment (TNA, 2024).

3. **Inter-sectoral Collaboration:** Insufficient coordination between the Ministry of Education and the Ministry of Health, compounded by a lack of awareness and commitment from school authorities and the community (Kamal and Hassan, 2022).

This confluence of national health challenges and systemic implementation barriers underscores the urgent need to formally assess the existing state of school health provisions against international standards.

### **1.3 Rationale and Alignment with National Policy**

The Government of Bangladesh has officially committed to advancing student health and well-being, evidenced by its signing of the regional "**Call for Action: Making Every School a Health-Promoting School**" during the WHO Southeast Asia Regional Office's inter-ministerial meeting in 2021. This action is part of a broader national strategy to revitalize HPS programming, aligned with the attainment of **Sustainable Development Goal**.

Furthermore, the government has recognized good health and well-being as an educational priority by introducing **wellbeing as a distinct subject** in the secondary and higher secondary school curricula, with new national textbooks developed in 2021.

This research is supported by a key partnership between the Directorate of Secondary & Higher Education (DSHE) and UNESCO Dhaka Office, established under an Implementation Partners Agreement (IPA). This collaboration aims to:

1. Conduct a comprehensive situation analysis.
2. Contextualize the Global HPS Standards and Indicators for the Bangladeshi setting.
3. Build capacity across the education system (teachers, head teachers, and administrators).

This study offers empirical evidence to support government decision-making in creating a sustainable roadmap for expanding the HPS model nationwide.

### **1.4 Objectives of the Study**

The **main objective** of this study is to conduct a comprehensive situation analysis of secondary schools in Bangladesh to examine the present condition of their health-promoting capacity against global HPS standards.

The specific objectives (SOs) are:

1. To examine the extent to which the school curriculum and textbooks related to health are **aligned with the Global HPS Standards**. (detail Global HPS standards statements are given the Annexure).
2. To assess the **physical and socio-emotional environment** of the school for promoting health among students and staff.
3. To identify the **available health services** at school to support students' health needs.
4. To assess the **integration of health education** in school teaching-learning practices.
5. To identify health-related **school policies and resources, governance, and leadership** for health promotion.

6. To assess students' **knowledge, attitudes, and practice (KAP)** regarding health, corresponding to their gender and location of the school.
7. To examine the **involvement of parents and community** members, along with other stakeholders' engagement, in planning and implementing health-promoting activities in schools.
8. To identify the primary **barriers and challenges** to implementing effective HPS programming in schools.

### 1.5 Scope and Methodology Overview

The study adopts a **convergent mixed-methods design** to collect both quantitative and qualitative data across a nationally representative sample of secondary schools in Bangladesh. The scope of the investigation is directly mapped onto the **Eight Global Standards of the Health Promoting School System** (WHO-UNESCO, 2021), as depicted in Figure 1 (to be inserted here).

The study encompassed the following key activities:

- **Desk Review:** A comprehensive analysis of national and international policy documents (Education, Health, Social Welfare) and existing curriculum, syllabus, and teacher training materials against global HPS standards.
- **Survey:** Administration of structured, self-reported questionnaires to students and teachers to assess KAB, environment, resources, and policy implementation.
- **Qualitative Data Collection:** Conducting Focus Group Discussions (FGDs) with students, teachers, and parents/community, and Key Informant Interviews (KIIs) with school head teachers, curriculum experts, DSHE officials, and District Health Officers.
- **Validation:** Organizing a consultation and validation workshop to gather feedback on the findings and finalize the situation analysis report.

This research will comprehensively examine the interrelationship among the school curriculum, day-to-day practices, students' health and socio-emotional well-being, and the Global Standards of the HPS.

### 1.6 Significance of the Study

The findings from this situation analysis are expected to provide an empirical, evidence-based roadmap for the effective scaling up of HPS initiatives in Bangladesh. The study holds significant value for multiple stakeholders:

- **Policymakers (DSHE, NCTB, Ministry of Health):** The data will be instrumental in designing targeted, evidence-based interventions, reviewing and aligning national policies, and allocating resources where HPS gaps are most pronounced.
- **Educators and Secondary School Administrators:** The findings will provide practical insights into the capacity building needs of teachers, particularly in addressing sensitive health topics and managing a positive school socio-emotional environment.
- **Development Partners (UNESCO, WHO, UNICEF):** The research offers a benchmark against which technical assistance and financial support for the DSHE-UNESCO IPA can be strategically focused.
- **Future Research:** The study establishes a baseline for subsequent intervention trials and longitudinal research on the impact of HPS implementation in South Asia.

By providing a deep and localized understanding of existing perceptions and practices, this study will directly contribute to improving the health and well-being of Bangladesh's future generation, fulfilling the promise of a truly health-promoting educational system.

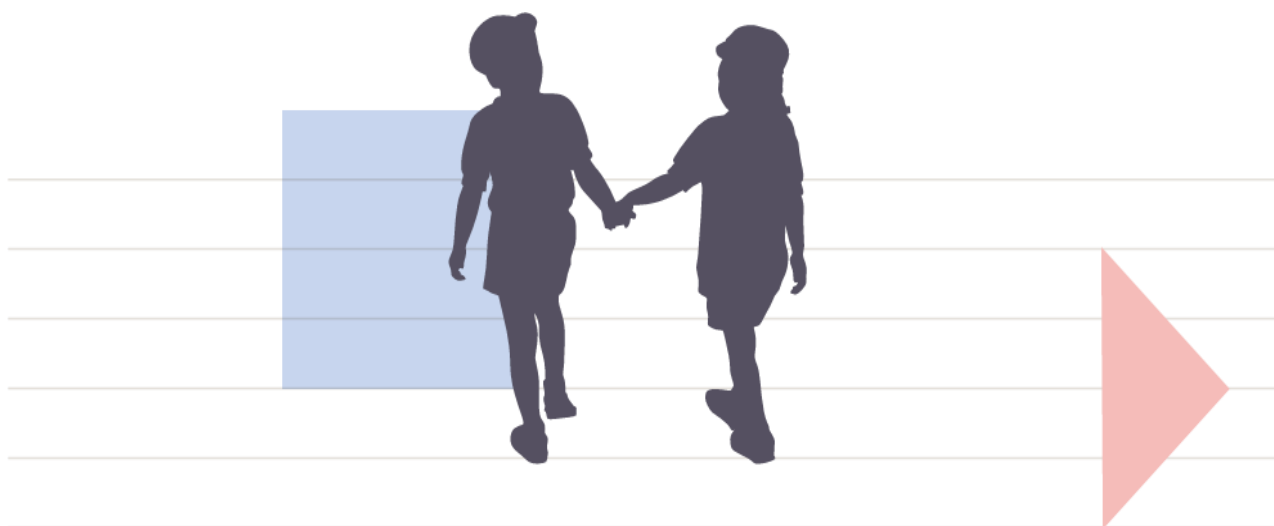
### 1.7 Commitment to Equity, Diversity, and Inclusion (EDI)

This study was fundamentally guided by the principles of **Equity, Diversity, and Inclusion (EDI)**. Upholding these principles was central to the research design and the development of relevant recommendations.

We demonstrated this commitment by:

1. **Ensuring Representation:** Actively ensuring that individuals from all relevant social and demographic identities (including gender balance, urban/rural schools, and schools in ethnic minority/disaster-prone areas, as noted in the Methodology) were provided ample opportunity to participate.
2. **Accessible Communication:** Utilizing diverse communication modalities and localized methods to reach a broad and representative spectrum of students, teachers, and community stakeholders.

This deliberate approach guarantees that the resulting situational analysis is not only statistically robust but also contextually equitable, leading to recommendations that address the unique health and well-being needs of diverse populations across Bangladesh.



## Chapter 2

### Literature Review

This chapter provides a critical synthesis of the extant literature concerning the Health Promoting School (HPS) framework, its national and global application, and its localized situation, and implementation challenges within Bangladesh. The review transitions from the global theoretical definition of HPS to a focused analysis of the national policy environment, existing health programs in schools, and the identified gaps in implementation. The objective is to critically analyze the present situation of HPS within the current school system aligned with the Global HPS Standards.

#### *2.1 The Global Health Promoting School (HPS) Framework*

The World Health Organization (WHO) defines an HPS as a setting that is "constantly strengthening its capacity as a healthy setting for living, learning, and working" (WHO, 1986). The HPS model is internationally recognized as a foundational strategy for addressing adolescent health and educational outcomes holistically.

The key conceptual shift inherent in the HPS model is its movement away from fragmented, curricular-only health instruction toward a comprehensive, whole-school approach. This mandates the integration of health promotion across eight interconnected domains (school policies, physical environment, curriculum, health services, etc.). The global evidence base suggests that successful HPS implementation yields positive results in areas such as reduced substance abuse, improved mental health literacy, and enhanced academic participation (St Leger, 2000).

Despite this clear global consensus, the literature often points to challenges in translating the holistic HPS model into diverse national contexts, frequently citing issues related to inter-sectoral inertia and sustainability mechanisms.

#### *2.2 The Policy Landscape in Bangladesh: Alignment and Disjuncture*

Bangladesh has established a foundational, yet dispersed, set of policies relevant to school health, though their operational alignment remains a significant challenge.

##### *2.2.1 Dispersed Policy Foundation*

The core policies are the National Education Policy (NEP), 2010, and the National Health Policy (NHP), 2011. While the NEP emphasizes the creation of a healthy school environment and curriculum development, the literature consistently highlights a "policy disjuncture" - a failure to fully integrate the mandates of the health and education ministries (WHO, 2024). This lack of formalized, empowered inter-ministerial coordination has been cited as a primary obstacle to operational effectiveness (WHO, 2024).

##### *2.2.2 Curriculum and Examination Gaps*

Following the NEP's recommendations, the National Curriculum and Textbook Board (NCTB) introduced a separate health and well-being book, "**Health Education**" textbook (Grades 6- 10). However, the literature identifies a critical structural flaw: the subject is **non-examinable**. This lack of formal accountability is known to diminish the perceived importance of the subject among both students and educators, potentially hindering effective implementation and resource prioritization. This challenge is further complicated by the recent introduction of the revised National Curriculum Framework (NCF) in January 2023, which dedicates substantial time to **Physical and Mental Health and Well-being** as a core learning subject. This additional subject appeared to be an extra burden over the regular curricula.

In response to growing recognition of schools as pivotal settings for lifelong health, the Government of Bangladesh has aligned with regional and global efforts to promote health-promoting schools. At the 74th session of the WHO

Regional Committee for South-East Asia, Member States (including Bangladesh) adopted Resolution SEA/RC74/R35, committing to revitalize school health programmes and implement comprehensive health-promoting school practices. To operationalize this, in October 2021, Health and Education Ministers of SEARO countries signed a Call to Action to scale up school health interventions, and a joint UN statement was issued advocating integrated, intersectoral investment in health, nutrition, mental health, and emergency preparedness in schools. Domestically, Bangladesh has taken steps by embedding the HPS framework in its national NCD action plan - proposing nutrition education, daily physical activity, mental health awareness for teachers, and tobacco-free school environments. This demonstrates not only political commitment across sectors but also translation into national-level action, aligning Bangladesh with WHO's Global Standards for Health Promoting Schools.

On 20 August 2025, Bangladesh achieved a landmark "whole-of-government" commitment to NCD prevention: secretaries from 35 ministries signed a Joint Declaration on Strengthening Inter-Ministerial Collaboration for Prevention and Control of Non-Communicable Diseases, under the leadership of Ministry of Health and Family Welfare (MOHFW). Crucially, the Ministry of Education is a signatory, and the declaration explicitly commits to introducing health promoting school as one of key intervention.

MOHFW is leading the institutionalization of the Health-Promoting School (HPS) approach within Bangladesh's NCD and mental health agenda. A joint Technical Committee with Ministry of Education (MOE) and Ministry of Primary and Mass Education (MoPME) is developing the HPS Implementation Framework, including the inter-ministerial coordination mechanism and operational guidelines. MOHFW has also convened WHO, UNESCO, UNICEF, WPP, and UNFPA to harmonize school health initiatives and align partner support under a single national vision, reducing duplication and ensuring coherence.

### ***2.2.3 Supplementary and Targeted Policies***

National health and education goals are supported by several targeted policies, including the National Strategy for Adolescent Health (2017-2030) and multisectoral action plan for prevention and control of NCDs, National Mental Health Act 2018, the National Mental Health Policy 2022, and the National Mental Health Strategic Plan 2020-2030, Tobacco Control Law 2005 with the National School Meal Policy (2019). These documents address specific public health challenges prevalent in Bangladesh, such as communicable and non-communicable diseases, nutritional deficiencies, mental health and injury prevention. While these documents exist, the implementation literature suggests that programmes (e.g., school feeding initiatives) are frequently hampered by funding shortages, weak governance, and poor institutionalization (IRIS, 2014; WHO, 2024).

## ***2.3 Status of HPS Implementation and Identified Gaps***

Implementation of HPS activities in Bangladesh remains largely **fragmented and in a formative stage**, often failing to transition from pilot programmes to sustainable national models.

### ***2.3.1 Environmental and Behavioral Disconnects***

Qualitative research reveals a significant disconnect between policy intent and on-the-ground reality:

- **School Food Environment:** Studies on urban school children indicate that schools often permit the sale of unhealthy foods (e.g., fried snacks, sugar-sweetened beverages) due to a focus on profitability and a lack of strict policy enforcement, directly contradicting HPS principles (Hasan et al., 2021).
- **Hygiene and Infrastructure:** While controlled trials show positive impacts on practices like handwashing following comprehensive interventions in rural areas, general school health programming suffers from inadequate infrastructure, specifically a lack of clean water, functional, gender-sensitive sanitation, and safe spaces for physical activity (TNA, 2025).

**Food environment and NCD risk factors:**

- Many schools allow the sale of unhealthy snacks, deep-fried foods, sugar-sweetened beverages, packaged ultra-processed products, and foods high in salt, sugar, and unhealthy fats- contradicting WHO recommendations for salt reduction, free sugar reduction, trans-fat elimination, and healthy food promotion.
- No school-level nutrition standards exist for canteens or for vendors operating around school premises, resulting in unregulated availability of unhealthy foods.
- There is no guideline for healthy meetings, trainings, workshops, seminars, or school events, which means teachers and students are routinely exposed to unhealthy refreshments.
- Schools rarely promote consumption of local fruits and vegetables, healthy snacking, hydration behaviors, or "healthy plate" concepts.
- Packaged food literacy is extremely low; students and teachers are not trained on food label reading, identifying harmful additives, or understanding high salt/sugar content.
- No skills-based interventions exist for healthy recipe development, simple cooking demonstrations, or healthy meal preparation, which are essential for behavior change and school-home practice transfer.

These conditions reinforce lifelong unhealthy dietary habits and increase risks of hypertension, obesity, diabetes, and cardiovascular diseases from an early age.

**Physical Activity Gaps**

Despite curriculum emphasis, structured physical activity remains limited:

- Many schools lack qualified Physical Education teachers, resulting in inconsistent implementation of sports activities.
- Daily physical activity recommendations (at least 60 minutes of moderate to vigorous activity) are not practiced or monitored.
- Playgrounds are inadequate, overcrowded, or completely absent in many schools; in some cases, academic pressure replaces allocated sports time.
- There is no provision for indoor or alternative physical activity for schools without adequate playground space.
- No schools follow a routine stretching or movement break between classes to interrupt long sedentary periods.

Physical activity for teachers is also absent-there is no structured "active teacher" programme, decreasing role-modeling potential for healthy behaviors.

### 2.3.2 Curriculum Content and Teacher Capacity

The recently conducted Training Needs Assessment (TNA, 2025) provides critical, immediate insights into capacity gaps:

- **Content Coverage:** Health content is unevenly presented across textbooks. While socio-emotional learning (SEL) has fair representation, crucial and delicate topics like reproductive health, immunization, mental health, and disaster preparedness receive minimal or decreasing attention in higher grades.
- **Teacher Training:** Teachers demonstrate foundational health knowledge but lack familiarity with structured HPS frameworks and specific pedagogical skills required to teach sensitive subjects and promote overall well-being. Therefore, it was recommended to provide appropriate training for developing teacher competencies.
- **Student Wellbeing:** Research, including the Global School-based Student Health Survey (GSHS, 2014) and subsequent studies (Hasan, M.M., et al., 2021, Sarker M. et al., 2017; ), consistently indicates that adolescents struggle with unhealthy food consumption, low physical activity, and a high prevalence of depressive and anxiety symptoms, often linked to academic pressure and feeling unsafe.
- **Fragmented Health Content:** Health topics are unevenly presented across textbooks. Socio-emotional learning (SEL) has fair coverage, but sensitive areas like reproductive health, immunization, mental health, and disaster preparedness receive minimal attention, especially in higher grades.
- **Teacher Capacity Gaps:** Teachers possess foundational health knowledge but lack training in structured Health-Promoting School (HPS) frameworks and specific pedagogical skills needed to address sensitive subjects and promote holistic student well-being.
- **Student Well-Being Challenges:** Evidence from the Global School-based Student Health Survey (GSHS, 2014) and subsequent studies indicates adolescents struggle with unhealthy diets, low physical activity, excessive screen time, and high levels of depressive and anxiety symptoms, often linked to academic pressure and unsafe school environments.
- **Life Skills Deficit:** Schools provide limited structured programmes for leadership, decision-making, problem-solving, self-esteem, coping strategies, and social or online etiquette. Peer leadership and student-led health promotion opportunities are underutilized.
- There are no systematic student-led initiatives to support elders, patients, farmers, or other community groups as part of graded or assessed learning.
- Schools do not implement hospital-based projects, local agriculture support programs, or other experiential learning opportunities linking students with real-world community needs.
- Opportunities to develop moral, social, and civic skills through community interaction are underutilized.
- Absence of such engagement limits students' practical application of life skills, empathy development, and understanding of societal responsibilities.

### 2.4 Research Gap and Study Positioning

The existing body of literature clearly establishes that Bangladesh possesses a decentralized policy foundation for school health, faces significant implementation barriers due to poor inter-sectoral coordination and resource shortages, and exhibits profound gaps in curriculum content and teacher capacity, especially concerning mental and reproductive health.

However, a comprehensive, integrated situational analysis that utilizes the internationally recognized Global HPS Standards and Indicators as the primary diagnostic tool is currently absent. Existing studies are often:

1. **Fragmented:** Focusing on single aspects (e.g., nutrition, hygiene, mental health).
2. **Qualitative or Small-Scale:** Lacking the quantitative breadth needed for national policy prioritization.
3. **Policy-Only:** Failing to link policy mandates directly to observable practices and stakeholder perceptions on the ground.

This study is therefore positioned to bridge this critical research gap. By employing a mixed-methods approach aligned with the eight Global HPS Standards, this research will produce a holistic, evidence-based assessment necessary to inform the formal development and institutionalization of a sustainable National HPS Framework for Bangladesh.



## Chapter 3 Methodology

### 3.1 Study Design

This research employed a Convergent Mixed-Methods Design to achieve a comprehensive understanding of the situational analysis for promoting health in secondary schools. Following the framework established by Creswell (2012), this design involved the simultaneous, yet independent, collection of both quantitative and qualitative data. The subsequent integration and merger of these datasets allowed for a robust, evidence-based interpretation of school health provisions and their alignment with the Global Health-Promoting Schools (HPS) Standards.

The integrated approach leveraged the strengths of both paradigms:

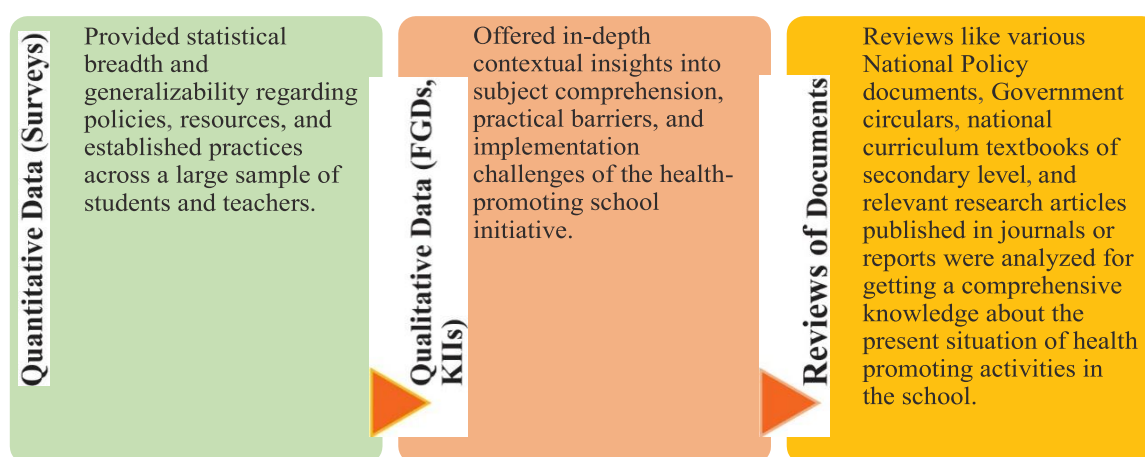
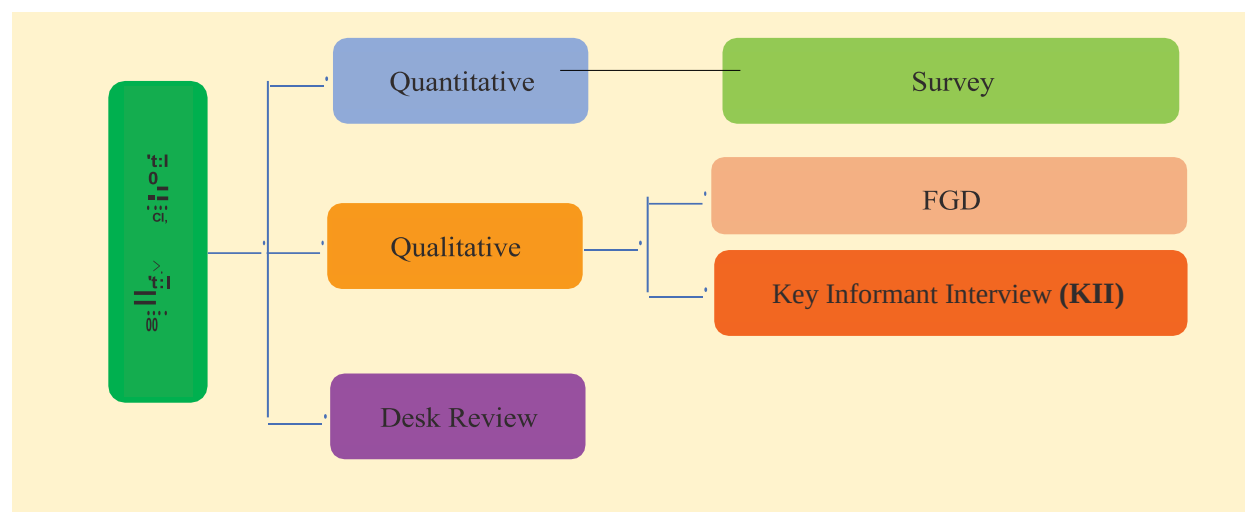


**Figure 3.1: The Study Design for the HPS Research Methodology.**



### 3.2 Research Setting and Scope

The study was conducted within the formal secondary education sector of Bangladesh, encompassing both public and private (MPO and non-MPO) secondary schools. The scope was limited to this sector due to its critical role in the education of a significant youth population.

Based on data from the Bangladesh Bureau of Educational Information and Statistics (BANBEIS, 2023), the population parameters at the time of the study were:

- **Students:** A total of 8,166,188 students were enrolled in secondary schools, with approximately 94% attending private institutions.
- **Teachers:** The total population of secondary school teachers was 246,784, with 94% employed in the private sector.

### 3.3 Quantitative Sampling Strategy and Sample Size

#### 3.3.1 Student Participants

The target sample size for student participants was determined using a standard formula for proportion-based studies, incorporating a 95% confidence level and a 5% margin of error, which yielded an initial required sample size of  $n=385$ . To minimize potential sampling error and non-response bias, the sample size was increased by approximately 25%, resulting in a final target sample of **480 students**.

#### Sampling Procedure:

1. **Multi-Stage Stratified Sampling:** The selection process utilized a multi-stage stratified design across the administrative hierarchy: division, district, and sub-district/upazila. All eight administrative divisions of Bangladesh were represented as primary strata.
2. **Simple Random Sampling:** Districts and sub-districts within the selected divisions were chosen using Simple Random Sampling (SRS).
3. **Purposive School Selection:** From each selected sub-district, **3 schools (1 public and 2 private)** were purposively selected to ensure heterogeneity and representation of diverse contexts:
  - o High-performance schools (urban and rural)
  - o Low-performance schools (urban and rural)
  - o Schools in disaster-prone areas
  - o Schools located in geographically challenging areas (Ethnic Minority areas, hill tracts, *hoar*, and *char* areas).
4. **In-School Random Selection:** Ten students were randomly selected from each participating school, with two students selected from each grade level (Grades 6 through 10) to ensure a balanced representation across the secondary cycle.
5. **Gender Distribution:** Reflecting the general enrollment pattern where 55% of secondary students are female, the sample maintained this distribution, resulting in approximately 50% female participants.

#### 3.3.2 Teacher Participants

A total of **five teachers** were purposively selected from each participating school.

**Teacher Selection Criteria:** Teachers were selected based on the following criteria to ensure their professional experience and relevance to the study's focus:

1. A minimum of two years of teaching experience in the current school.
2. Current responsibility for teaching subjects directly or indirectly related to health and well-being, including Physical Education and Health, Science, Bangladesh and Global Studies, Work and Life Oriented Education, or Home Science.

Details of the planned sample size are shown in the following Table 3.1.

**Table 3.1: sampling of district, upazila, schools, teachers and students for Quantitative Approach.**

| Division   | District | Sub-District/<br>Upazila | No. of schools<br>3 (1 publ c + 2 Private) | Student<br>Participants | Teacher<br>Participants |
|------------|----------|--------------------------|--------------------------------------------|-------------------------|-------------------------|
| Dhaka      | 2        | 2                        | 2*3=6                                      | 6* 10 =60               | 6*5 =30                 |
| Chattogram | 2        | 2                        | 2*3=6                                      | 6* 10 =60               | 6*5 =30                 |
| Barishal   | 2        | 2                        | 2*3=6                                      | 6* 10 =60               | 6*5 =30                 |
| Khulna     | 2        | 2                        | 2*3=6                                      | 6* 10=60                | 6*5 =30                 |
| Rajshahi   | 2        | 2                        | 2*3=6                                      | 6* 10=60                | 6*5 =30                 |
| Rangpur    | 2        | 2                        | 2*3=6                                      | 6* 10 =60               | 6*5 =30                 |
| Mymensingh | 2        | 2                        | 2*3=6                                      | 6* 10=60                | 6*5 =30                 |
| Sylhet     | 2        | 2                        | 2*3=6                                      | 6* 10=60                | 6*5 =30                 |
| Total      | 16       | 16                       | 48(16 public+ 32 private)                  | 480                     | 240                     |

### 3.4 Qualitative Sampling Strategy and Sample Size

Qualitative data were collected through Focus Group Discussions (FGDs) and Key Informant Interviews (KIs) using a **purposive sampling strategy** to select participants who possessed specific knowledge, experience, or authority relevant to school health promotion.

- **FGD Participants:** Included students, teachers, and parents/community members.
- **KI Participants:** Included head teachers, curriculum specialists, and relevant government officials from the Directorate of Secondary and Higher Education (DSHE), District Education Office (DEO), and District Health and Welfare offices.

**Table 3.2: Selections of respondents by their category and number for qualitative approach.**

| Respondents                      | Data collection technique | Selection strategy | Selection criteria                                       | Number |
|----------------------------------|---------------------------|--------------------|----------------------------------------------------------|--------|
| Students                         | 8FGD                      | Purposive          | Variety of grades, gender, and school types              | 80     |
| Teachers                         | 8FGD                      | Purposive          | Experienced, health-related subject teachers             | 40     |
| Parents/community                | 8FGD                      | Purposive          | Actively involved in school or community health issues   | 40     |
| Head teachers                    | 8 KII                     | Purposive          | Leadership role, experience managing school policies     | 8      |
| Curriculum specialist            | 1 KII                     | Purposive          | Direct involvement in health education curriculum design |        |
| Govt. officials (Edn. & Healths) | 3 KII                     | Purposive          | Policy implementation and oversight roles                | 3      |

### 3.5 Data Collection Instruments

The study utilized a comprehensive suite of instruments, detailed below, with several informed by the World Health Organization's (WHO) **Assessment of National Education Systems for Health (ANESH)** and the **Global Standards of Health-Promoting Schools (HPS)**.

#### 3.5.1 Structured Survey Questionnaires

**A. Teacher Survey Questionnaire:** The questionnaire consisted of two main sections:

1. **Part I:** Demographic and professional information.
2. **Part II:** Items derived from the WHO ANESH, focusing on key domains related to the HPS framework: physical and socio-emotional school environment, integration of health education in teaching, available health services, school policies and resources, governance and leadership, and school-community partnership.

**B. Student Survey Questionnaire:** The questionnaire consisted of three main sections:

1. **Part I:** Demographic information.
2. **Part II (KAP Survey):** Designed to assess students' Knowledge, Attitude, and Practice (KAP) related to various health topics.
3. **Part III:** Items informed by the WHO ANESH and HPS standards, covering student perceptions of the physical and socio-emotional school environment, health education, school services, and governance.

#### 3.5.2 Qualitative Interview Guides

**A. Focus Group Discussion (FGD) Guides:** The FGD guides were structured around the **eight domains of the Global HPS Standards** to ensure thematic coverage across all respondent groups:

1. Government Policies and Resources
2. School Policies and Resources
3. School Governance and Leadership
4. School and Community Participation
5. School Curriculum
6. School Socio-emotional Environment
7. School Physical Environment
8. School Health Services

**B. Key Informant Interview (KII) Guide:** The KII guide utilized the same framework of the eight HPS Global Standards to elicit high-level, policy-oriented insights from administrative and subject-matter experts.

#### 3.5.3 Curriculum and Textbook Review Checklist

A specialized '**Health and Wellbeing Content Evaluation Checklist**' was developed for the desk review. This checklist was adapted and refined from an initial version used in a Training Needs Assessment (TNA) study, incorporating elements from both the **WHO-UNESCO ANESH** and **HPS Standard 5 (Curriculum)**.

The checklist employed a five-point Likert scale to evaluate the depth and breadth of content coverage, divided into six main thematic areas and a total of 29 sub-themes:

1. Socio-emotional Learning (SEL)
2. Health and Healthy Lifestyle (HHL)
3. Prevention of Circumstances (PC)
4. Reproductive Health (RH)
5. Environmental Health and Sustainability (EHS)
6. Socio-cultural Issues (SCI)

### 3.6 Ethical Considerations

The study adhered strictly to all ethical guidelines and protocols mandated by the Human Research Ethics Advisory Panel of the Institute of Education and Research, University of Dhaka, from which formal ethics approval was obtained.

Key ethical principles applied throughout the research process included:

- **Informed Consent:** Obtaining written informed consent from all adult participants and informed assent, supported by consent from a legal guardian, for all child respondents (students).
- **Anonymity and Confidentiality:** Ensuring that participant identities were protected and that all collected data were kept confidential, with reporting done only in aggregated form (Babbie, 2014; Truscott et al., 2019).
- **Voluntary Participation:** Clearly assuring participants of their right to refuse participation or withdraw from the study at any time without penalty or consequence.
- **Minimization of Harm:** Actively minimizing any potential physical, social, or psychological risks or discomforts arising from the research procedures, ensuring the safety and well-being of all respondents.

## Chapter 4

### Data Analysis and Result

The chapter is organized into three main analytical sections, followed by the integration of findings: (1) descriptive analysis of the current situation of the respondents, (2) detailed analysis across the eight RPS domains, and (3) a review of the curriculum content.

#### 4.1 Descriptive Profile of Study Participants

This initial section establishes the demographic and professional context of the participating students and teachers, ensuring the reader understands the characteristics and representativeness of the sample used for the quantitative analysis.

##### 4.1.1 Students' Profile

This study planned to conduct an individual survey among 480 students taken from 48 secondary schools of eight Divisions of Bangladesh. Finally, 458 students' responses were found valid. Thus, the total students sample size is now 458 of which 41.7% (191) is male and remaining 58.3% (267) is female. Their demographic variation as per type of school is given in the following table 4.1. The table represents girls' representation more in the sample than the boys'.

**Table 4.1. Distributions of students as per their school type and gender.**

| Type of school    | Boys        | Girls       | Both       |
|-------------------|-------------|-------------|------------|
| Government        | 101         | 110         | 211        |
| Non-Gov. (MPO)    | 86          | 153         | 239        |
| Private (non-MPO) | 4           | 4           | 8          |
|                   | 191 (41.7%) | 267 (58.3%) | 458 (100%) |

The survey data also indicated that 75% of the students belong to the urban schools while 25% study in rural schools.

The class wise distribution of the students is given in Table 4.2 below. It shows that we have more or less equal representation of the students from the schools except class ten where they represent little less than the other groups of students.

**Table 4.2. Class wise distribution students.**

| Class | Number | Percentage |
|-------|--------|------------|
| Six   | 98     | 21.4%      |
| Seven | 84     | 18.3%      |
| Eight | 99     | 21.6%      |
| Nine  | 116    | 25.3%      |
| Ten   | 61     | 13.3%      |

#### 4.1.2. Students' KAP survey status

To assess students' current knowledge, attitude, and behavioural practices regarding health and its practice, three assessment scales were developed and used. The research team prepared these scales based on a priori knowledge and tested them for appropriateness. Though not standardized, the scales provided significant results regarding the students' present level of knowledge, attitude, and practice in their daily lives.

The findings of the three measures are given in the following Table 4.3.

**Table 4.3. Mean score of knowledge, attitude and practice of students in the matters of health and well-being. (data in parentheses indicates SD)**

|          | Knowledge<br>(Max. score is 30) | Attitude<br>(Max. score is 66) | Practice<br>(Max. score is 30) |
|----------|---------------------------------|--------------------------------|--------------------------------|
| Boys     | 13.27 (2.50)                    | 50.71 (5.01)                   | 24.16 (2.87)                   |
| Girls    | 12.46 (2.76)                    | 50.29 (9.07)                   | 24.02 (4.71)                   |
| Both sex | 12.80 (2.68)                    | 50.46 (7.64)                   | 24.08 (4.04)                   |

Table 4.3 reveals that students demonstrated poor overall health knowledge, scoring an average of 12.8 out of 30. Though generally low, boys scored slightly higher (13.27) than girls (12.46). (for detail please see the knowledge test items in the Annexure). The reason of low achievement in the knowledge test may be attributed to under coverage of some contents of health and well-being in their textbooks. These contents belong to psycho-social aspects of health, link between health and environment, gender issues etc.

For attitude towards health and well-being, students achieved a mean score of 50.46 on a scale of 22 to 66, indicating a moderate level of positive attitude. The difference in attitude scores between genders was not significant, suggesting that boys and girls hold similar views on the issue. Comparatively higher attitude of students towards health and well-being may reflect the impact of mass media, and other health departmental campaigns of the government (such as Ministry of Social Welfare, Health and Family Planning Ministries etc.) and other NGOs.

In contrast to their knowledge and attitude scores, students showed a good position in practicing healthy behaviors. Their overall mean practice score was 24 out of 30, a significantly high result. Similar to attitude, the difference in practice scores between boys and girls was not significant. While robust health practices are often lacking in many school environments, these students reported positive behaviours based on their personal perceptions.

Analysis of the students' Knowledge, Attitude, and Practice (KAP) status was conducted based on academic grade and class. The findings indicated minimal inter-class variation in test scores across all KAP domains. Students consistently demonstrated poor knowledge scores across all grades. Conversely, their attitude scores toward various health-related phenomena were moderately high among all classes. Compliance in practicing healthy behavior was observed to be moderately high across all student groups (class-wise KAP results are given in Table (4.1).

Despite a significantly high practice of healthy behaviours, students demonstrated generally poor knowledge and only a moderate attitude toward overall health and well-being. Gender differences in attitude and practice were insignificant, while boys showed only slightly higher knowledge scores than girls.

## 4.2. Teachers' Profile

This study conducted an individual survey among 206 teachers taken from 48 secondary schools of eight divisions of Bangladesh. These teachers were taken from a pool of 240 teachers, where 34 teachers were either absent during the survey or rejected for their non-response in the survey. Thus, the total teachers sample size is 206 of which 64.1% (132) are male and remaining 35.9% (74) is female. In general, the secondary schools are less represented by female teachers (27.5%, BANBEIS 2021) than male teachers. The fewer number of female teachers reflects their representation in the whole teacher population. Their demographic variation as per type of school is given in the following table 4.1. The table shows that girls' schools are more in the sample than the boys' school.

**Table 4.1. Distributions of teachers according to their school type, category, location and gender**

| Type of school                 | Category                    | Location             | Gender               |
|--------------------------------|-----------------------------|----------------------|----------------------|
| Government<br>80 (38.8%)       | Boys' school 29<br>(14.1%)  | Urban 145<br>(70.4%) | Male 132<br>(64.1%)  |
| Non-Govt. (MPO)<br>118 (57.3%) | Girls' school 56<br>(27.2%) | Rural 55<br>(26.7%)  | Female 74<br>(35.9%) |
| Private (non-MPO)<br>8 (3.9%)  | Co-education 121<br>(58.7%) | Remote 6<br>(2.9%)   |                      |
| Total - 206                    | 206                         | 206                  | 206                  |

The table above indicates that a large majority of the schools were non-government (MPO), co-educational, and located in urban areas. The gender distribution shows that male teachers dominated the sample, accounting for two-thirds of the total. It is, however, expected that this teacher representation in the sample is logical and reflective of the overall teacher population.

The following Figure 4.4 illustrates the general and professional educational qualifications of teachers across all school categories, broken down by gender. The figure shows that nearly three-fourths of male teachers (72%) and two-thirds of female teachers (69%) held a general Master's Degree. In contrast, less than a quarter of both male (21.2%) and female (19%) teachers had only a Bachelor's Degree. Similarly, around three-fourths of both male and female teachers held a B.Ed. degree, while those with a M.Ed. degree were fewer in number. Based on these figures, it can be concluded that the overall teacher population is generally well-qualified for secondary schools in Bangladesh.

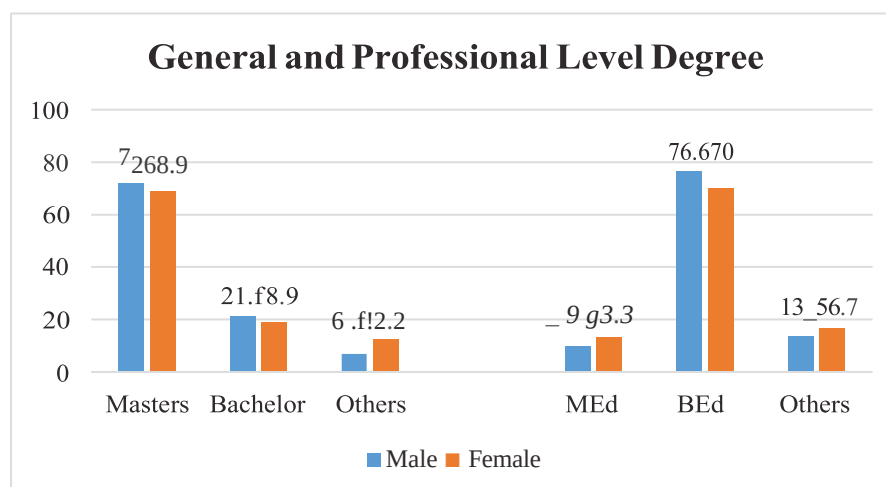


Figure 4.4. Teachers' general and professional level degrees in percent.

#### 4.2.1. Teachers' training background on health education

Teachers were asked to indicate if they had ever received any training on health education in the past. In response to this question only 62 (30.1%) persons mentioned that they received this training in the past and their responses are plotted in the following Figure 4.5.

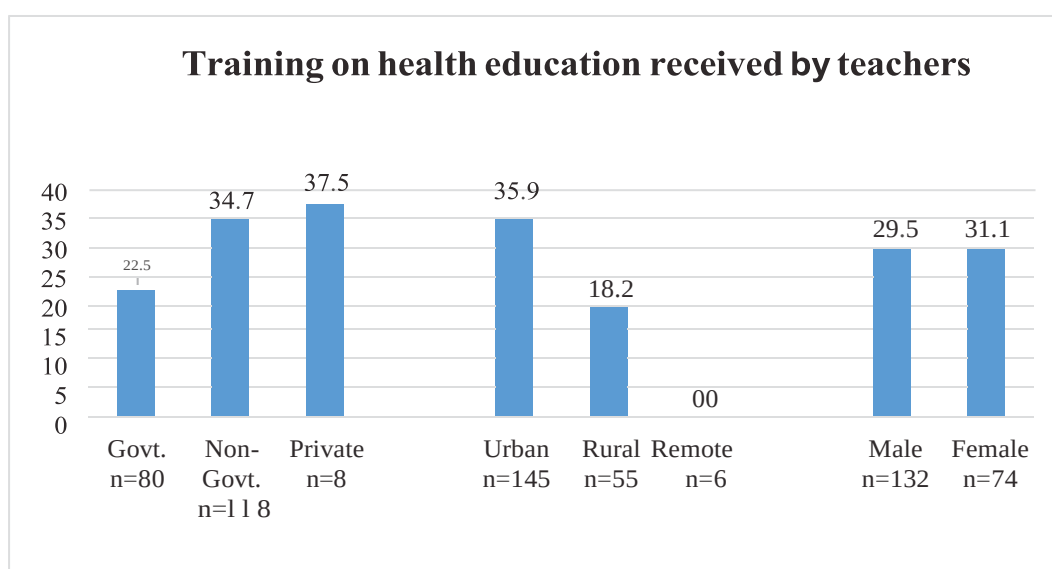


Figure 4.5. Teachers' background of training on health education is differentiated by school type, location and gender.

The figure paints a concerning picture of teachers' training in health education. Only about 30% of all teacher categories reported receiving training in some form of health education or well-being subject. Government school

teachers lag behind their non-government (MPO) counterparts, with only 22.5% trained compared to 34.7%. Similarly, rural school teachers lag behind urban teachers significantly (18.2% vs. 35.9%). However, gender variation is negligible, remaining at roughly 30% for both male and female teachers.

Teachers also indicated the duration of such training they received on health and well-being education. However, it was not certain that what subjects were exactly dealt in the training. In Focus Group Discussion with teachers, they expressed their inability to remember specific content of those training. Among those who received training mentioned that it was 1-2 days for 74.2%, and 3-5 days for 21.0%; only 4.8% teachers received more than five days training. The result is shown in the following Figure 4.6.

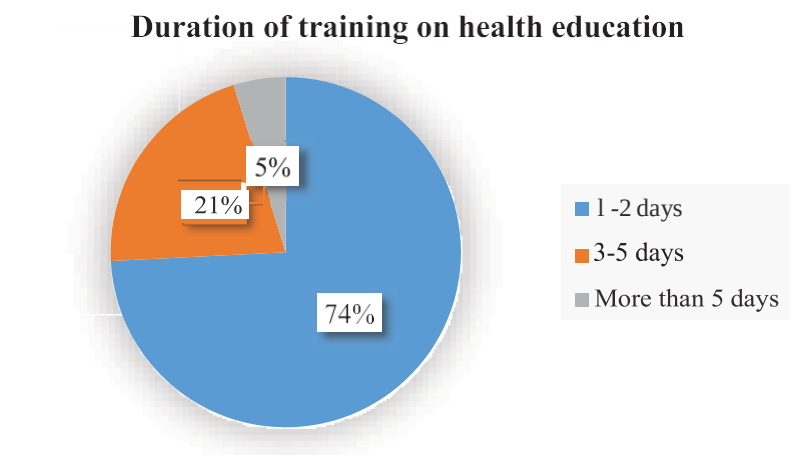


Figure 4.6. Duration of teachers' training on health and well-being that they received in the past.

The data shows that Health and Hygiene and Physical Education subjects are largely neglected, with only 8.2% of the 206 responding teachers reporting they taught them. Because these subjects are excluded from the final examination, teachers have little incentive to prioritize them. Teaching these optional subjects is not a formal duty for any teacher; instead, the responsibility is often assigned to whichever teacher is available.

#### **4.2.2. Other categories of respondents**

Among other categories of the respondents were 8 Head Teachers from 8 division of the country. One Education Officer, one Health Education Officer, and a Curriculum expert from NCTB. These people were purposefully selected to determine the overall scenario of the school health condition. They were considered Key Informant individuals for cross examining the overall survey on the basis of KIL. Their interview findings were used for cross-checking the obtained results from the students, teachers, and other community people like parents and other individuals associated with the school.

Participants included in the Focus Group Discussion (FGD) were students (of all five classes), teachers, parents and relevant community members. Both the parents of the present and past students, and local community leaders associated with the school (managing committee members, retired officials etc.) were taken as participant for the focus group discussions. In total of about 80 students, more than 50 teachers, nearly 100 parents took part in the FGD conducted simultaneously during the data collection procedure.

### 4.3. Students' Responses about the Health and Well-being of the School

#### 4.3.1. Student Perceptions and Health Status

Analysis of the previous sections indicates that while students possess poor formal knowledge of health and well-being, they demonstrate an awareness of healthy scenarios and behavioral conditions within the school environment. This awareness allowed them to identify deficiencies across several domains: national and school-level policies, school administration, the physical environment, the curriculum, and the provision of health services.

**Table 4.4** provides data on the students' self-perceived regular health conditions. The data reveal a concerning pattern:

- A significant proportion of students reported suffering from visual and hearing problems.
- A similar number of students self-identified as belonging to the "ill health group."
- Despite these findings, approximately half of the students reported being free from any sickness while at school.

This disparity suggests a need for further investigation to reconcile the high incidence of reported specific conditions (visual/hearing/ general ill health) with the number of students who perceive themselves as entirely healthy (Details are given in Table 4.4).

**Table 4.4. Percentage of students indicating their perceived health condition around the year.**

| Criteria                             | Type of student         |                           | Gender of student |                  |
|--------------------------------------|-------------------------|---------------------------|-------------------|------------------|
|                                      | Govt. school<br>N = 211 | Private school<br>N = 239 | Boys<br>N = 191   | Girls<br>N = 267 |
| Mostly I remain sick                 | 6.63                    | 8.79                      | 5.76              | 9.36             |
| I suffer from stomach problem        | 4.74                    | 1.25                      | 2.09              | 3.37             |
| Generally, I am an ill health person | 27.01                   | 29.29                     | 27.74             | 28.09            |
| I have visual problems               | 29.86                   | 16.32                     | 21.46             | 23.22            |
| I have hearing problems              | 8.53                    | 7.11                      | 10.47             | 5.99             |
| I suffer from obesity                | 9.95                    | 8.37                      | 13.09             | 6.37             |
| I do not have any health problem     | 49.73                   | 45.19                     | 56.54             | 53.56            |

#### 4.3.2. Policy awareness of the students

This section aimed to assess students' awareness of existing health education policies or school-level health-related regulations. A mixed response was observed: 35.59% of students reported being aware of a national health education policy, while the majority (62.22%) responded negatively or expressed ignorance. In response to another question, 27.0% of the students mentioned that despite other things they have to follow certain health rules strictly in school. In this matter there are variations in response among the students by types of school and gender but they are not very significant. While students are not expected to possess detailed knowledge of national policies, their curiosity and awareness are likely derived from observing school activities, rules and the health services provided. The low awareness figures highlight a potential need to better communicate policy implications or school health rules to the student body.

Focus group discussions with students revealed that they generally lacked awareness of the specific policy. While a small number of participants speculated that such documentation might exist, the majority were unaware of its contents. However, students did maintain a clear understanding that their school operates under a set of established rules they are expected to follow.

One aspect of the study examined student perceptions regarding the school's policy on diversity, specifically its responsiveness to the varied nature of the student body, including factors such as religion, ethnic origin, disability, or intellectual ability. Students were asked whether their school acknowledges and admits this diversity. The distribution of their responses is detailed in Table 4.5.

**Table 4.5. Percentage of students indicating the nature of student accepted in their schools.**

| Students' background           | Government school<br>(N = 211) | Non-government school<br>(N = 239) |
|--------------------------------|--------------------------------|------------------------------------|
| All religious background       | 93.36                          | 84.94                              |
| Any tribal background          | 53.08                          | 43.51                              |
| With any disability            | 45.50                          | 31.80                              |
| Of any intellectual background | 76.30                          | 78.66                              |

The data in Table 4.5 indicates a variation in the extent to which schools are perceived to admit diversity. While it was universally reported that students of various religious backgrounds are admitted across all schools surveyed, the same level of inclusion was not observed for all other forms of diversity.

A notable and somewhat unexpected finding was the reported lack of acceptance for children with disabilities (particularly, moderate to severe types of disability) in a substantial number of the schools. This particular observation warrants further investigation to determine the specific factors and rationales contributing to these reported admission patterns among the schools.

#### **4.3.3. Integration of health education in teaching learning practice**

Health education is formally provided in secondary schools through a dedicated textbook titled, "Physical Health Education". However, the delivery of health education is not restricted to this specific class; teachers commonly integrate relevant health components found within other subjects, such as Bangladesh and Global Studies and General Science textbooks. (Grades VI - X).

The standard instructional practice among teachers is to adhere strictly to the prescribed content outlined in the textbooks. This often results in a limited discussion of topics, omitting necessary details or contexts that fall outside the official curriculum.

Notwithstanding the general practice, a subset of teachers voluntarily elaborates on the content and incorporates supplementary, non-prescribed materials into their instruction. To document and explore this spontaneous practice, students were surveyed to identify specific health topics that these teachers informally discuss during routine lessons. Student responses detailing these supplementary topics are presented in Table 4.6.

**Table 4.6. Student-reported health topics casually discussed by teachers in daily lessons(%).**

| Subject                               | Government school<br>(N = 211) | Non-govt. school<br>(N = 239) |
|---------------------------------------|--------------------------------|-------------------------------|
| How to find health information        | 47.86                          | 63.60                         |
| Importance of hand wash               | 66.35                          | 73.64                         |
| Importance of vaccination             | 66.82                          | 66.53                         |
| Risk of consuming fat, sugar and salt | 54.98                          | 57.32                         |
| Benefits of balanced diet             | 77.25                          | 79.50                         |
| How to control obesity                | 31.75                          | 37.24                         |
| Parasite/worm control                 | 49.76                          | 56.48                         |
| Maintaining health and nutrition      | 61.61                          | 69.87                         |
| Resolve conflict peacefully           | 70.62                          | 75.31                         |
| Controlling mental stress and anger   | 45.02                          | 61.08                         |
| Importance of physical education      | 68.25                          | 78.24                         |

Analysis of Table 4.6 data reveals that a substantial majority of teachers integrate diverse health education information into their instruction, typically during relevant subject lessons. This includes content directly specified in the prescribed textbooks. Key themes consistently highlighted by teachers include hand washing, vaccination, balanced diet, nutrition, and conflict resolution. Notably, a significant difference was observed in the frequency of this integrated teaching: non-government school teachers demonstrate greater engagement in sharing this information compared to their counterparts in government schools. This discrepancy between government and non-government school warrants further investigation as it suggests a potential sectoral inequality in health literacy instruction.

#### **4.3.4. Physical and socio-emotional environment in the school**

The School Environment constitutes a critical determinant of educational outcomes and student well-being within the Health Promoting School (HPS) framework. It is conventionally understood through two interconnected dimensions, the Physical Environment and the Socio-emotional Environment. The Physical Environment encompasses the material features of the school, including the safety, cleanliness, accessibility of facilities (e.g., sanitation, playgrounds, clean water), and the aesthetic quality of the campus. Simultaneously, the Socio-emotional Environment reflects the intangible atmosphere of the school, defined by factors such as the quality of student relationships, the presence of emotional and effective conflict resolution mechanisms. This study analyzed and compared how these environments manifest and are maintained in government and non-government schools as perceived by the students. Their responses are indicated in the following Table 4.7.

**Table 4.7. Students' perceived report about the physical and socio-emotional environment in their school(%).**

| Subject                                               | Government school<br>(N = 211) | Non-govt. school<br>(N = 239) |
|-------------------------------------------------------|--------------------------------|-------------------------------|
| School environment is pollution free                  | 34.60                          | 49.37                         |
| Classrooms are spacious & well ventilated             | 64.45                          | 69.46                         |
| Have playground and necessary play equipment          | 61.14                          | 68.62                         |
| Have separate canteen with healthy food               | 25.12                          | 27.61                         |
| Have safe drinking water facility                     | 59.71                          | 69.46                         |
| Trash cans are placed at different places             | 71.56                          | 79.08                         |
| Have sufficient clean and useable toilets             | 36.02                          | 57.74                         |
| There are safe common room for students               | 28.91                          | 44.35                         |
| Place for disposing used sanitary napkins for girls   | 21.80                          | 29.71                         |
| Have a separate health worker for advising students   | 7.58                           | 28.03                         |
| There is an assigned teacher who gives health support | 58.77                          | 52.72                         |
| The school has anti-bullying rules for students       | 39.34                          | 50.63                         |
| Students try to maintain social harmony               | 82.46                          | 82.84                         |

The physical and socio-emotional environment of the surveyed schools was evaluated based on students' perceptions. As indicated in Table 4.7, non-government schools were consistently rated as providing a superior environment compared to government schools.

A significantly larger proportion of students in non-government schools reported that their facilities were better in terms of spacious and well-ventilated classrooms, they have playgrounds, have better drinking water facility, use consistently trash cans for waste disposal, and maintain cleaner toilets and separate resting room for students.

Health-related support also varied by school types. Over half of all surveyed schools reported having an assigned teacher to oversee students' health issues. However, the presence of a dedicated, separate health worker for emergency support was markedly different. More than one-quarter (25%) of non-government school students reported having a separate health worker, only 7.5% of government school students reported access to this facility.

Regarding the social environment, approximately half of the students in non-government schools reported the presence of a normal anti-bullying rule. On the other hand, a large majority (over 82%) of students in both government and non-government schools confirmed that they actively strive to maintain social harmony among the student body.

The student perception data clearly indicates a notable disparity in the provision of physical infrastructure and dedicated health support between non-government and government schools. Non-government schools generally offer a richer physical environment and significantly greater access to dedicated health personnel. While this difference exists, it is encouraging that students across both school types exhibit a strong commitment to maintaining social harmony, suggesting that the essential social-emotional goal of positive peer relationships is being largely met irrespective of the school's administrative structure.

#### 4.3.5. Provision of health service in school

A healthy learning environment is a prerequisite for academic achievement and holistic development. Consequently, the provision of comprehensive health services in schools serves as a foundation for supporting student well-being, addressing minor health needs, and promoting preventative care. The effectiveness of these services, however, is best evaluated from the perspective of their primary users. This section of the report focuses on the theme: 'Provision of health services in school' as perceived by students. The primary objective of this analysis is to systematically explore, analyze, and document student perceptions regarding the availability of health services within their respective schools.

To assess the current state of service provision, students were asked to indicate which specific health provisions were offered by their school. The data below presents the students' collective view on the availability of health services, showing the percentage of students who reported each item as being available:

|                                                             |       |
|-------------------------------------------------------------|-------|
| • Conduct regular health checkup                            | 33.6% |
| • Parents invited in health checkup program                 | 26.9% |
| • School has emergency arrangement for accidental situation | 43.0% |
| • Connected with local clinic for healthservice             | 47.8% |
| • External health workers are involved in health checkup    | 38.9% |

#### 4.3.6. Students' knowledge about environment and provisions

This section presents a comprehensive assessment of the participating students' knowledge regarding environmental issues and the provisions available in their school to address them.

The students' understanding of environmental awareness and potential remedies is detailed through an analysis of their responses to relevant questions. Specifically, their knowledge of school-based provisions is explored, providing crucial insight into how well these resources are understood and utilized. The findings presented here, expressed in percentages representing student opinions, offer crucial data. This information is intended to inform the development of more effective, targeted, and curriculum-aligned health education interventions tailored for this vital age group students.

|                                                                     |       |
|---------------------------------------------------------------------|-------|
| • Students have knowledge about the service during emergency        | 72.1% |
| • Have knowledge about the sources of mental support in school      | 59.6% |
| • Students expressed that their class is crowded                    | 50.4% |
| • Students think that their school situated in dirty andnoisy place | 16.9% |

#### 4.3.7. School-community partnership for students' well-being

To assess the effectiveness of the school-community partnership for students' well-being, this section details the statistical and thematic analysis of the collected information. The presentation is structured to first highlight student perceptions of well-being from family perspective, followed by an evaluation of current community involvement, concluding with an integrated discussion of how the partnership impacts student health outcomes.

|                                                                      |       |
|----------------------------------------------------------------------|-------|
| • Parents encourage health practice at home for student              | 92.8% |
| • Students think parents know human health problems well             | 54.0% |
| • Students think that their family is solvent for taking health care | 83.3% |
| • School involved in health campaign programme                       | 37.8% |
| • School takes part in immunization program                          | 79.3% |
| • School campaigns in favour of non-communicable diseases            | 26.2% |
| • School conduct workshop on adolescence or drug addiction           | 23.0% |

The data indicates that student healthcare primarily relies on parental support, with a significant 92.8% of students receiving regular care from their parents at home. This reliance is supported by the students' belief in their parents' capacity, as 54% view their parents as knowledgeable about their health and a large majority of 83.3% consider them financially capable. While the family serves as the main provider, the school plays a secondary, yet focused, role in health provision, most notably through high participation in the immunization programme (79.3%), followed by much lower levels of engagement in awareness campaigns for non-communicable diseases (26.2%) and adolescents' problems (23%).

#### 4.4. Teachers' Responses about the Health and Well-being of the schools

##### 4.4.1. Teachers' perception of policy existence

Despite the lack of an official standalone Health Education Policy, a significant proportion of teachers reported believing that such a policy exists (though in FGD teachers could not specifically mention any of such policy). Specifically, 61.2% of responding teachers (n=126) affirmed the existence of such a policy. Another 7.8% of responding teachers (n=16) replied that no such policy exists. However, 31.1% of responding teachers (n=64) expressed uncertainty or ignorance regarding the existence of any policy. Gender variations are there but not very significant. (For gender segregated statistics, please see Annexure Table 4.4)

This contradiction between documentary evidence and teacher perception suggests a significant gap in understanding among the teaching cohort regarding official policy status.

When teachers who affirmed the existence of the policy were asked to identify the subjects included within it, they consistently cited the content already present in the existing Health and Hygiene textbooks for various grade levels (for details, see Figure 4.7). The underlying cause of this misreporting appears to be a lack of direct access to and knowledge of official policy documents. Focus group discussions (FGDs) with teachers further corroborated this finding, indicating that they do not possess the appropriate knowledge of or access to important educational and related policy documents.

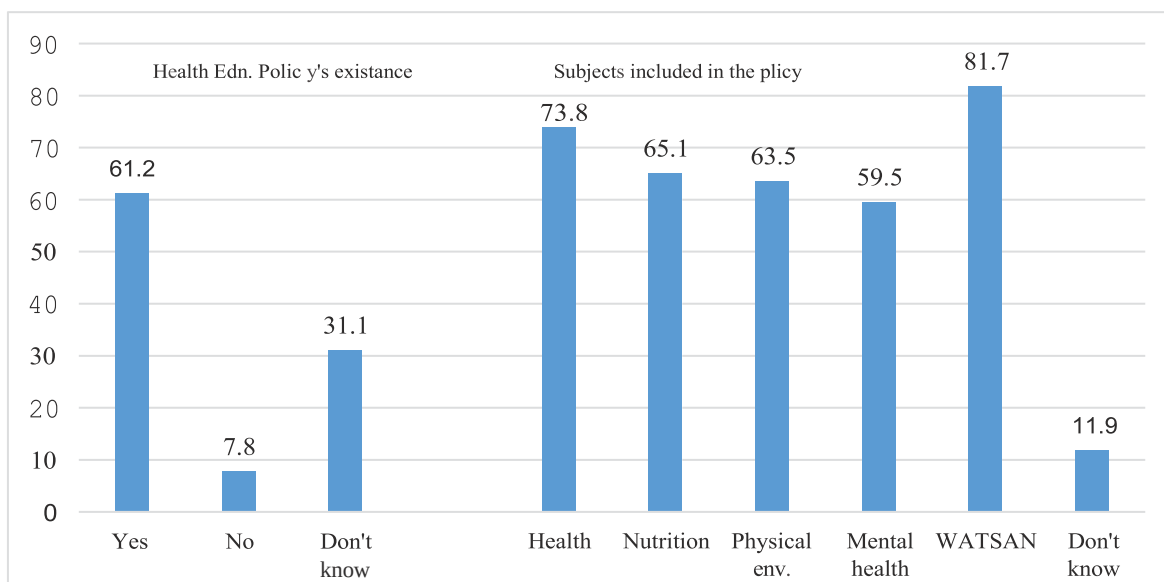


Figure 4.7. Teachers' perceived knowledge about health education policy and its integrated subject in the book (in%).

#### 4.4.2. Health education linked to the National Education Policy

The National Education Policy (NEP 2010) serves as the comprehensive framework for education in the country and is intended to cover most relevant subjects, including health education. The findings indicate a divided awareness among the teaching cohort, such as, more than half of the teachers (54.4%) reported being aware of the NEP 2010. Gender-based analysis reveals that awareness levels are nearly identical, with 52.3% of male and 58.1% of female teachers expressing familiarity with the document. Despite this, a substantial portion of the teaching staff remains uninformed of its specific details. Data from surveys and Focus Group Discussions (FGDs) suggest that many teachers lack a clear understanding of the National Education Policy and its relationship to health-related services. Though Bangladesh does not currently have a dedicated National Health Education Policy, teachers frequently confused this concept with localized school health guidelines. Consequently, 61.2% of respondents (59.1% male and 64.9% female) claimed that their institutions possessed an independent school health policy.

Teachers who were aware of the NEP 2010 were subsequently asked to indicate the extent to which the health education components are reflected within the Policy. Their responses are visually represented in Figure 4.8. The figure further reveals that a large proportion of teachers possess limited knowledge regarding the specific content of the health education curriculum. (see Annexure Table 4.4 for gender variation)

A comparative analysis of the data presented in Figure 4.7 (subjects mentioned by teachers in the perceived policy) and Figure 4.8 (perceived reflection of health education in NEP 2010) highlights a critical issue that, teachers exhibited a poor level of foundational knowledge regarding the existence and detailed content of both a dedicated Health Education Policy and the health components within the comprehensive National Education Policy 2010, yet they still provided definitive responses to questions raised in this study.

This observation underscores a significant systemic weakness in the overall management and dissemination of critical policy documents to teachers, as well as a failure to emphasize the importance of policy knowledge to the wider educational audience.

#### 4.4.3. Existence of school health policy

A substantial majority of teachers (81.1%) reported that their schools follow specific health and well-being regulations. However, this quantitative data is challenged by qualitative insights from Focus Group Discussions (FGDs) and Key Informant Interviews (KIs). While teachers noted that schools provide necessary services on an ad hoc basis, these efforts lack formal structure and documentation. Consequently, despite high levels of reported awareness, many staff members remain uninformed about the specifics of existing policies. This issue is addressed in the positive findings related to the research questions:

|                                                                            |             |
|----------------------------------------------------------------------------|-------------|
| • Do schools have health and environmental policy in favour of students?   | Yes (88.3%) |
| • Do schools think there is a health guide or principles for the students? | Yes (67%)   |
| • Do schools have any positive psycho-social rules that ensures:           |             |
| o Social justice                                                           | Yes (70.4%) |
| o Gender equity                                                            | Yes (51.0%) |
| o Religious tolerance                                                      | Yes (72.3)  |
| o Inclusiveness of diverse ability                                         | Yes (20.9%) |
| o There is no such rule                                                    | Yes (16.7%) |

The above responses indicate a significant gap between policy existence and effective implementation/awareness at the school level in Bangladesh, suggesting a trend toward decentralized, institution-specific rule-making that may lack standardization and widespread communication.

Despite the very high affirmative response for health and environmental policies indicates that the physical well-being and surrounding environment are recognized as key policy areas in most schools. While a majority report rules for general psycho-social issues like Religious Tolerance (72.3%) and Social Justice (70.4%), the rate for Gender Equity (51.0%) is noticeably lower, suggesting this area may be a secondary concern or less formalized in half of the schools.

The strikingly low figure for "Inclusiveness of diverse ability" (20.9%) demonstrates a severe policy weakness and systemic failure regarding students with disabilities or special needs. This indicates that school health policies are overwhelmingly designed for the general student population, marginalizing a significant vulnerable group. Besides all the facts, 16.7% of teachers' report "no such rule" exists for psycho-social well-being; they further reinforce the inconsistency and potential fragmentation of policy across schools.

National Education Policy (NEP 2010) is a comprehensive education policy that recommends to cover most of the relevant subjects. It was found that more than half of the teachers (54.4%) are aware of it but large number of them are still unaware of it. The informed teachers were asked to mention how far the health education components are reflected in this Policy. Response to this question is depicted in Figure 4.8.

The Figure 4.8 also demonstrates that the large number of teachers has little knowledge about the contents of health education curriculum. When we consult Figures 4.7 and 4.8 then it becomes evident that teachers have poor level of knowledge about the existence of health and education policy yet, they respond to research questions without understanding of the policies and their content details. This finding suggests that the overall management system is weak in terms of disseminating policy documents among teachers and communicating their importance to the wider education community.

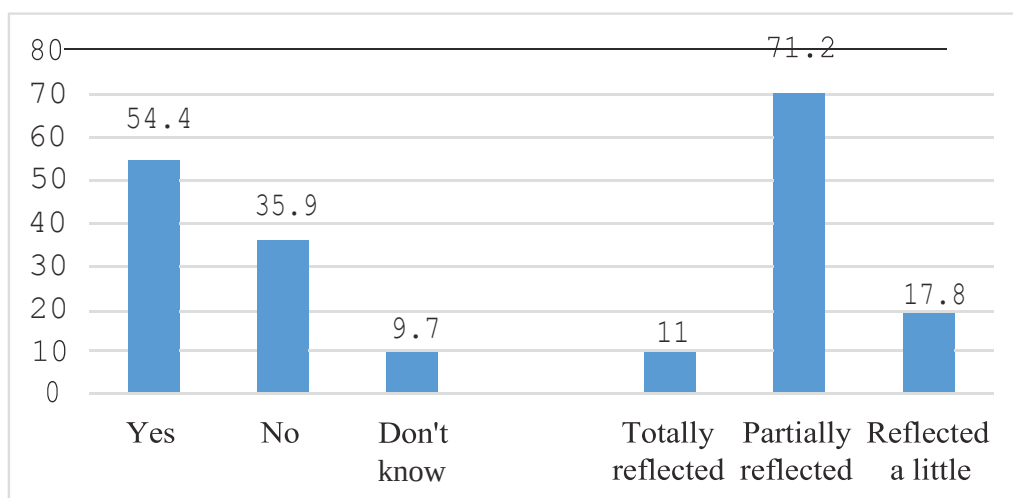


Figure 4.8. Teachers' perception in% about Health Education and NEP connection.

#### 4.4.4. Status of school health policies and services

School health services are not regular programmes in Bangladesh. Some vital services like, health checkup, eye test, immunization, etc. are available in the school depending upon their financial resources and leadership of the head teacher of the school. Another source of the availability of the services is the government national programmes (like Social Welfare Ministry, Health and Family welfare department) and local NGO initiative. When teachers were asked to indicate the availability of health service, they mentioned those names. Teachers' responses about availability of health services are indicated in the following Figure 4.8.

**Table 4.8. Health services available in the sampled schools as indicated by teachers. (in %)**

| Services       | Types of schools       |                              | Locations of schools    |                        |
|----------------|------------------------|------------------------------|-------------------------|------------------------|
|                | Govt. school<br>(n=80) | Non-govt. school<br>(n= 118) | Urban school<br>(n=145) | Rural school<br>(n=55) |
| Health checkup | 33.7                   | 30.5                         | 36.5                    | 20.0                   |
| Eye test       | 46.2                   | 37.3                         | 46.2                    | 29.1                   |
| Immunization   | 71.2                   | 78.0                         | 78.6                    | 70.9                   |
| Others         | 26.2                   | 25.4                         | 25.5                    | 25.4                   |

The health and well-being services in schools are not significant. The services do not vary much among the type of schools and or its locations. Among the health services, immunization was found to be highest in the list. The reason of this magnitude is due to its universal delivery in the country by government. After immunization eye test and other health checkup programmes are also provided by different NGOs in the country and without cost. A quarter of the teachers mentioned of other health services that are undertaken by the school either independently or in collaboration with government or non-government agencies. To mention the other services, mid-day meal, mental health service, hand washing programme, sanitation programme etc. are prominent.

#### 4.4.5. School health governance and leaderships

In order to get a comprehensive idea of the school health services and their governance, they were asked to mention about their management, monitoring, collaboration, and budgeting system. Teachers' responses are given in the following Table 4.9.

**Table 4.9. Governance of health services in school as indicated by teachers. (in%)**

| Service mechanisms               | Govt. schools | Non-govt. schools | All schools |
|----------------------------------|---------------|-------------------|-------------|
| Self-monitoring                  | 46.3          | 57.6              | 52.2        |
| External monitoring              | 32.5          | 57.6              | 46.6        |
| Have separate budget             | 19.7          | 18.8              | 20.0        |
| Obtained training                | 15.0          | 20.3              | 18.4        |
| Collaboration with other schools | 5.0           | 2.5               | 3.4         |
| Conuu...,J                       | 10.0          | 8.5               | 10.2        |

Table 4.9 shows that the school health services currently available are mostly inadequate and are dependent on external agencies.

Regarding monitoring, more than half of the teachers reported that their health activities were self-monitored while the remaining teachers indicated their services were externally monitored. It is evident from the table that approximately one-fifth (20%) of the schools have a separate budget for the service. The other schools must fund these activities from their general budget, which poses a problem. Funding for this service is either absent or the amount approved by the authority is very limited.

Only a few teachers provide these services with proper training. In the absence of such training, one school informed the team that they employed a dispensary compounder to provide emergency medical support, who was also a school peon. Though the evidence is limited, it was found that 3 to 5 percent of the schools organize health services in collaboration with neighboring schools or conduct a joint project (10%) with other schools.

#### 4.4.6. School and community partnership

The promotion of school health and well-being necessitates a collaborative approach extending beyond the school's boundaries. Maintaining an effective health environment and ensuring student well-being requires the involvement of external stakeholders. Key stakeholders include the School Managing Committee (SMC) or Governing Body, local health workers, law enforcement agencies, and parents. However, when asked about the support provided by these external agencies, most teachers in the FGDs and Klis were skeptical, citing a lack of tangible evidence. For instance, some respondents noted, "Except for the SMC/Governing Body, these groups rarely provide immediate assistance or respond to our specific needs."

To assess the extent of this collaboration, teachers were surveyed regarding the school's practice of seeking external assistance to maintain a healthy school environment. The affirmative responses indicate a significant degree of external engagement, as detailed below:

|                                                                         |       |
|-------------------------------------------------------------------------|-------|
| • Involvement of the School Managing Committee (SMC) for proper action: | 49.0% |
| • School utilizes the support of local health workers:                  | 44.7% |
| • Involvement of local law enforcement agencies:                        | 51.5% |

These results clearly illustrate that nearly half of the surveyed schools actively utilize local external resources to maintain a safe psycho-social environment.

In the Focus Group Discussions (FGD), teachers elaborated on the role of these external agencies, specifically mentioning their importance in keeping the surrounding areas of the school safe from unwanted disturbances. These disturbances include issues such as eve-teasing (street harassment), student bullying, and other social conflicts.

The process of engaging community stakeholders for school health initiatives is complex and often faces significant challenges. Teachers reported various obstacles and barriers that impede successful interaction and collaboration with the community. These obstacles were identified by respondents through a survey questionnaire, and the primary hindering factors are presented below:

|                                                           |       |
|-----------------------------------------------------------|-------|
| • Lack of Necessary Funding:                              | 77.7% |
| • Lack of Appropriate Manpower:                           | 60.7% |
| • Teachers' Excessive Workload:                           | 48.0% |
| • Local Doctors' Engagement with Patients (Lack of Time): | 34.9% |

The reported barriers are substantial and necessitate targeted interventions. The most significant obstacle is the lack of necessary funding, cited by over three-quarters of respondents. Successfully advancing school health and well-being initiatives within the country will require adequate financial resources, strategic planning, and the sympathetic cooperation of all involved parties.

#### **4.4.7. Reflections of health and well-being contents in curriculum**

One of the main sources of education for health and well-being is the school curriculum. The content analyses of health education and other books show that school curriculum covers many subjects like, adolescence, health, social well-being, student conflict, drug addiction, suicide etc. This study thus intended to determine teachers' awareness of those contents in the textbooks of secondary education. Based on the questions of the survey, teachers endorsed the following points that were covered in the books:

|                                                                     |       |
|---------------------------------------------------------------------|-------|
| • Health and socio-emotional contents are reflected                 | 75.7% |
| • Contents on adolescents and their changes are reflected           | 90.3% |
| • Road safety, addiction and suicide are reflected                  | 71.7% |
| • Feel confident and free from any disgrace in teaching adolescence | 76.2% |

The school curriculum serves as a primary source for health and well-being education. Content analysis of health education and related textbooks reveals coverage of diverse subjects, including adolescence, health, social well-being, student conflict, drug addiction, and suicide.

This study aimed to determine teachers' awareness of these specific health-related contents incorporated within the secondary education textbooks. The following points were endorsed by teachers in the survey, indicating their awareness of the material covered in the curriculum:

- |                                                                                              |       |
|----------------------------------------------------------------------------------------------|-------|
| • Health and socio-emotional contents are reflected:                                         | 75.7% |
| • Contents on adolescence and related changes are reflected:                                 | 90.3% |
| • Road safety, addiction, and suicide are reflected:                                         | 71.7% |
| • Teachers feel confident and free from any disgrace in teaching adolescence-related topics: | 76.2% |
| • Teachers believe that they have enough training to teach these                             | 32.5% |

The high rates of teacher awareness regarding the inclusion of critical health and well-being topics-especially those concerning adolescence (90.3%) and socio-emotional health (75.7%)- demonstrate a strong foundation for curriculum delivery. Furthermore, the finding that over three-quarters (76.2%) of teachers feel confident and comfortable teaching sensitive adolescence-related content suggests that the existing curriculum is well-integrated and that there is a receptive pedagogical environment for these subjects. This widespread awareness and confidence are essential for effectively utilizing the curriculum as a tool to promote student health and well-being. But in order to teach these contents, only one third of teachers feel that they have enough training for handling these contents. This finding necessitates proper training for the teachers so that majority can feel safe and secured for handling such sensitive contents among the adolescents.

#### 4.4.8. Physical and social emotional environment in school

Creating an optimal physical and socio-emotional environment in school is not an easy task-it is an intentional and pedagogical practice. Teachers are responsible for actively curating the physical space, organizing materials, managing classroom flow, and ensuring safety to maximize student focus and engagement. For this practice to be successful, the school must provide certain favorable conditions, such as well-ventilated classrooms, teacher satisfaction with the working environment, and adequate health facilities. When educators successfully establish a climate of psychological safety and high expectations, they directly unlock students' motivation, resilience, and deepest academic potential. To assess the foundation for this, teachers were asked to indicate the availability of specific physical provisions in the school that reflect the overall health situation. Teachers' responses are shown in Table 4.7.

**Table 4. 7 Teachers' perceived report about the physical and socio-emotional environment in their schools(%)**

| Subject                                        | Government schools<br>(N = 80) | Non-govt. schools<br>(N = 118) |
|------------------------------------------------|--------------------------------|--------------------------------|
| Satisfied with current physical environment    | 35.0                           | 33.9                           |
| Satisfied with light and air flow of the class | 73.8                           | 78.0                           |
| Have playground in school                      | 87.5                           | 84.7                           |
| Schools have gardens                           | 67.5                           | 54.2                           |
| Have emergency sick room                       | 52.5                           | 51.2                           |
| Have part-time/full-time nurse                 | 3.7                            | 4.2                            |
| Provision primary health care services         | 72.5                           | 74.6                           |
| Referral service for health checkup            | 26.25                          | 40.7                           |
| Regular counseling service                     | 25                             | 39.8                           |
| School have a health corner                    | 23.7                           | 33.0                           |
| Provide mid-day-meal                           | 52.5                           | 11.9                           |

The table above indicates that a large majority of teachers reported having a playground and well-ventilated classrooms. Approximately two-thirds of urban schools have gardens. While many schools provide health care services and an emergency sick room, only about half of urban school teachers confirmed the availability of a mid-day meal program. Conversely, the existence of a school nurse is almost nonexistent. Regarding support services, regular counseling is available for only a quarter to one-third of students, and a similar fraction (one-quarter to one-third of teachers) mentioned having a referral service for emergencies.

#### 4.5. Textbook Content Analysis for Health Education

This section provides a detailed account for the contents given in the textbooks of secondary education curriculum related to health education leading towards promoting school health programme. Various components of health education has already been incorporated in the curriculum through a few relevant subjects like, Physical Health Education (PHE), Bangladesh and Global Studies (BGS) and Science Textbooks across classes VI to X. However, other subjects like Bangla and English literature, History, Geography, and Mathematics also reflected a few health information in some relevant sections which are not considered as significant because of their fragmented or incomplete reference. Subjects like Agriculture and Home Economics do contain some health education contents but those subjects are optional for the students; thus the books were not included in the analysis.

In order to analyze the content, a specialized 'Health and Wellbeing Content Evaluation Checklist' was developed for the desk review. The purpose of this review is to explore the extent to which the existing textbooks align with Standard 5 for HEALTH AND WELL-BEING CONTENTS (UNESCO, 2020). This checklist was adapted and refined from an initial version used in a Training Needs Assessment (TNA) study, incorporating elements from both the WHO ANESH and HPS Standard 5 (Curriculum).

The health and well-being contents are divided into six main themes and several sub-themes. In all 29 sub-themes are identified under six main themes. The main themes are:

1. **Socio-emotional Learning (SEL):** It is an educational method that integrates in the development of social and emotional skills into school curricula.
2. **Health and Healthy Lifestyle (HHL):** A healthy lifestyle is a valuable resource for reducing the incidence and impact of health problems, for recovery, for coping with life stressors, and for improving quality of life.
3. **Prevention of Circumstances (PC):** This can be defined as a state of readiness to respond to a disaster, crisis, or any other type of emergency situation that is injurious to health, hygiene or mental state.
4. **Reproductive Health (RH):** This is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.
5. **Environmental Health and Sustainability (EHS):** It comprises those aspects of human health, including quality of life, that are determined by physical, chemical, biological, social and psychosocial factors in the environment.
6. **Socio Cultural Issues (SCI):** Sociocultural issues refer to differences between groups of people relating to the social class and culture in which they live.

For analyses of the health and well-being content in the textbook, a five-point indicator scale is developed. The five-point indicators are:

|                         |   |
|-------------------------|---|
| Fully represented       | 5 |
| Mostly represented      | 4 |
| Largely represented     | 3 |
| Partially represented   | 2 |
| Very little represented | 1 |

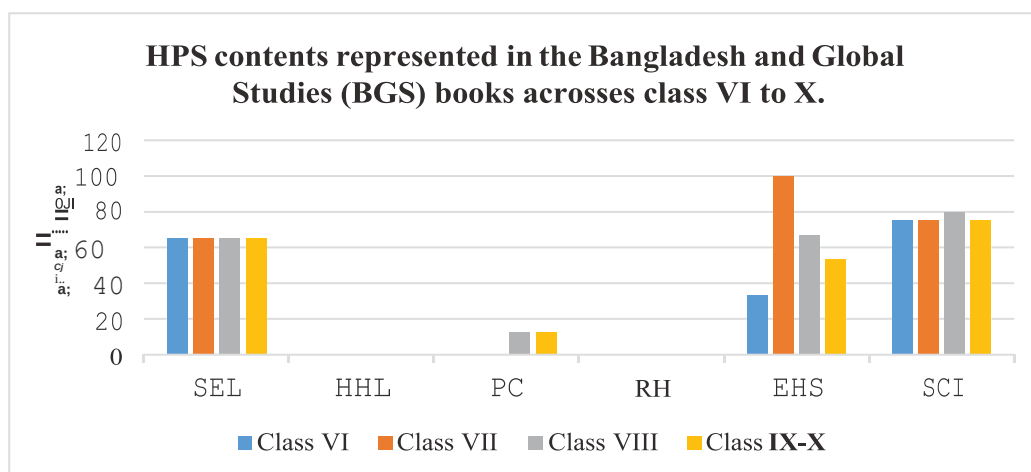
Each topic was scored based on the length of the text, the depth and breadth of discussion, and the presence of diagrams or pictures in the textbook.

For example, if there is a separate chapter or more than 80 to 100% of the content covered discussing the topic then a score of "5" was assigned which denotes 'Fully represented.' Similarly, if a topic captured more than 60 to 79% of the content, a score of "4" was assigned which denotes 'Mostly represented.' For a topic covering around 50% of the content, a score of "3" denoting 'Largely represented' was assigned and a covering less than 50% denotes to 'Partially represented', with a score of 2. Finally, a score of "1" denoting 'Very little representation' was assigned to topics covering less than 10% of the content. The analysis was done for three subjects like, Bangladesh and Global Studies (jGS), Physical Health and Education (PHE) and Science textbooks across class VI to X. The detailed analysis is given in the following pages through a graphical representation in terms of percentage.

#### 4.5.1. Content analysis of Bangladesh and Global Studies (BGS) textbooks.

The Bangladesh Global Studies (BGS) is a subject that is included in the secondary school curriculum from classes VI to X with an expectation to cover all the relevant six themes necessary for health and wellbeing of students. Based on that expectation, the textbook was critically analyzed to determine the extent of each theme in the book. The findings of the analysis are shown in the following Figure 4.9.

Figure 4.9: Health and Well-being Contents in BGS Textbooks (Classes VI-X).



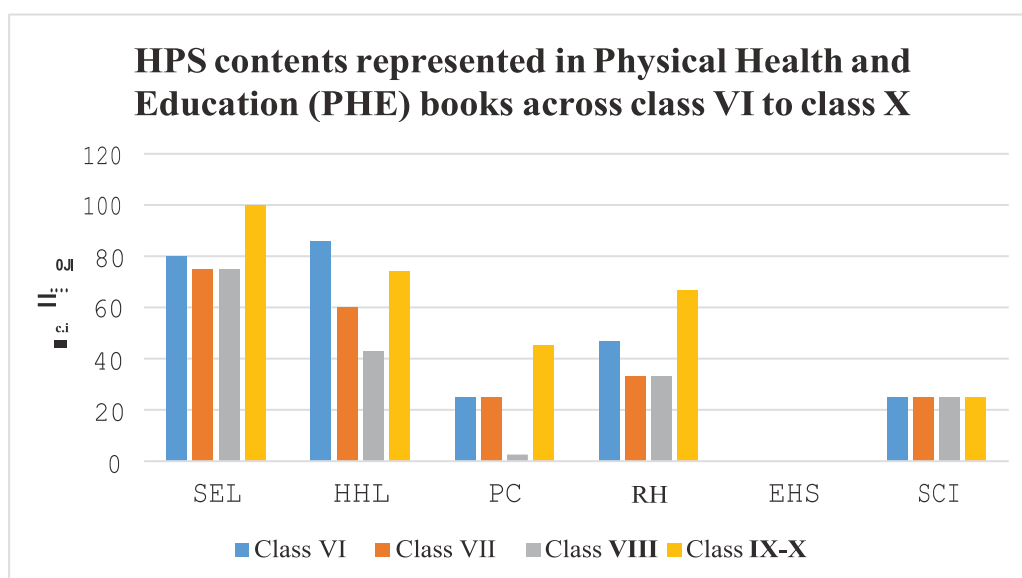
[SEL=Socio-emotional learning, HHL=Health and Healthy Lifestyle, PC=Prevention of Circumstances, RH=Reproductive Health, EHS=Environmental Health and Sustainability, SCI= Socio Cultural Issues]

The figure (4.9) illustrates the percentage of expected contents (i.e., representation) of health and well-being in *Bangladesh and Global Studies* textbooks across classes VI to X. It shows that the contents on the Socio-emotional learning (SEL) is represented in all classes (VI, VII, VIII, IX-X) to the extent of 65%. The content on Prevention of Circumstances (PC) has very low representation only in class VIII and Class IX-X, where its representation is about 12.5 percent. The content on Environmental Health and Sustainability (EHS) is fully represented (100%) in class VII while it is 66.67% in class VIII and 53.33% in classes IX-X. Representation of this content is shown to be partial or 33.33% in class VI. The contents of Socio-Cultural Issues in BGS is found mostly represented. It is found 75% in classes VI, VII and IX-X. While class VIII covers almost 80% contents on SCI. The contents on Health and Healthy Lifestyle (HHL) and Reproductive Health (RH) is totally missing in the BGS across all grades or classes.

#### 4.5.2. Content analysis of Physical Health and Education (PHE) textbooks

The subject Physical Health and Education (PHE) covers necessary contents on Physical Education reflecting all the six themes and sub-themes in the textbooks in the secondary school curriculum from classes VI to X with an expectation to cover all the relevant themes necessary for health and wellbeing of students. The content analyses of these books are shown in the following Figure 4.10.

Figure 4.10: Health and Well-being Contents in PHE Textbooks (Classes VI-X).



[SEL=Socio-emotional learning, HHL=Health and Healthy Lifestyle, PC=Prevention of Circumstances, RH=Reproductive Health, EHS=Environmental Health and Sustainability, SCI= Socio Cultural Issues]

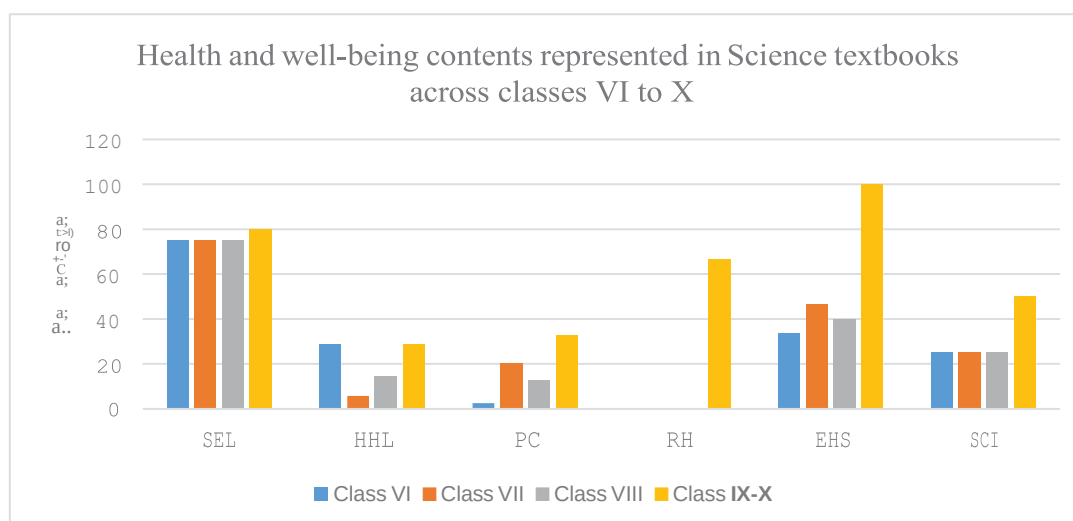
This Figure 4.10 presents the percentage of health and well-being contents across six categories (SEL, HHL, PC, RH, EHS, SCI) represented in Physical Health and Education (PHE) textbooks for classes VI to X. SEL content is consistently high across all classes, ranging from 75% to 100%, with Class IX-X being the highest. Class VI shows

a presence of 80%, whereas classes VII and VIII both show 75% presence. HHL content representation is also substantial, though more varied, with Class VI having the highest percentage of 85.71% and Class VIII the lowest with 42.86%. On the other hand, class VII and IX-X shows 60% and 74.29% representation respectively. PC content shows very low representation overall. For class VIII the rate is the lowest with only 2.5% evidence, but reaches 45% for Class IX-X. In class VI and VII PHE textbooks, the representation rate is 25% each. Reproductive Health (RH) is also represented, with Class IX-X at about 66.67% and Class VI shows 46.67% presence of health and well-being contents. Notably, the EHS category indicates no representation across all classes. Finally, SCI contents are represented uniformly across all classes, situated at 25%.

### 4.5.3. Content Analysis of Science textbooks

General Science is a common subject in all classes of the Secondary Education Curriculum. General Science curriculum that progressively introduces and deepens understanding across the major scientific disciplines: Biology, Chemistry, and Physics, alongside topics in Environmental Science and Health. These books also deal with the Health and Wellbeing contents parallel to the relevant chapters. Figure 4.11 provides the extent of Health and Wellbeing contents that are reflected in the relevant chapters of the subject in different classes.

Figure 4.11: Health and well-being contents in Science textbooks (classes VI to X).



[SEL=Socio-emotional learning , HHL=Health and Healthy Lifestyle, PC=Prevention of Circumstances, RH=Reproductive Health, EHS=Environmental Health and Sustainability, SCI= Socio Cultural Issue]

Figure 4.11 presents the percentage of health and well-being contents in Science textbooks across classes VI to X. SEL content is the most consistently represented, with 75% presence in classes VI to VIII and the highest percentage (80%) is seen in class IX-X. HHL content shows variation in presence in Class VI and IX-X being the highest with 85.71%, and Class VII, being the lowest with 5.71%. However, the presence of HHL topics in class VIII is 42.86%. Presence of PC content is the lowest in class VI (2.5%), while the highest percentage is in class IX-X (32.5%). In class VII and VIII, respectively 20% and 12.5% of the total contents represent the existence of PC topics. The presence of RH topics is only evident in Class IX-X with 66.67% representation, while Class VI to VIII show no existence of RH topics in the Science textbooks. Environmental Health and Sustainability (EHS) is significantly prominent in Class IX-X, showing the widest range of representation, largely driven by the high value in Class IX-X at 100%. However, classes VI, VII and VIII illustrate the existence of EHS topics with 33.33%, 46.67% and 40% respectively. Percentages SCI content is consistent at 25% from class VI to VIII, with Class IX-X being the highest in showing 50% existence of SCI topics.

## Chapter 5

### Discussion and Recommendations

A Health Promoting School is characterized by a collaborative environment where students, teachers, administrators, and parents work together to achieve the common goal of implementing developmental health education. To evaluate the status of health education within secondary schools in Bangladesh, a situation analysis was conducted. This study involved the participation of nearly all relevant stakeholders in the educational program, including over two hundred teachers and more than four hundred students, who provided input through surveys, group discussions, and individual interviews.

The key insight from this research is that, while most individuals at the institutional level have some understanding of education and health, the addition of the concept of *improvement* or *development* complicates matters. Although education, health, and social well-being are interconnected, they are organized and managed by three separate Ministries (Ministry of Health and Family Welfare, Ministry of Education, and Ministry of Social Welfare) which do not have necessary inter-ministerial coordination and interaction amongst them. As a result, the responsibility for improving health and well-being often falls solely on schools.

#### **5.1. Reflections of health-education in school activities**

Different national policies often fail to reach the grassroot levels effectively. As a result, policy implementing agencies and their staff on the ground are largely unaware of these policies. When a ministry is tasked with implementing a policy, the responsibility is typically delegated through circulars. However, the implementation of health and education policies involves more than just one ministry or department. This lack of inter-departmental coordination makes it challenging to implement many policies, forcing agencies to resort to alternative methods for carrying out government orders (Kamrul, Ahsan 2010; Jabbar, Abdul 2025). For instance, while schools need to be cleaned, the necessary funds for other essential activities are often not allocated. Additionally, even though there is a policy aimed at addressing students' mental health issues, trained counselors are frequently absent in schools. Despite some adherence to national policies, educational institutions often create their own policies tailored to their specific needs. Although these institution-specific policies may share certain basic similarities, their implementation processes and effectiveness can vary widely. For example, the use of corporal punishment, such as caning to manage student behavior, has been discontinued; yet, the prevalence of mental harassment has not significantly decreased.

#### **5.2. Reflection of school level policy**

Since the establishment of the school system in the country, the education and health of students have been widely discussed. In any ideal educational institution, attention should be paid to both aspects, but various valid reasons make it challenging to implement this concept effectively. During the data collection for this study, most teachers and school officials expressed agreement on this matter.

It appears that students are also aware of the connection between education and health as they answered nearly all questions in this context while providing their information. Although the opinions of teachers closely align with those of the students, the students' perspectives seem less biased in many cases. Most students believe that the school does not follow proper policies regarding health and education (it is their speculation because they have not seen any policy). Students voiced together that most of the school surroundings and WASH facilities are not tolerably clean. They feel that the physical and psycho-social environment of the school is generally substandard,

and the school does not take adequate initiatives to protect the mental health of its students. Social activities are also organized occasionally (like annual sports, cultural programme, religious festivals etc.)

### **5.3. Head teachers' leadership in the school**

Education, health, and student well-being in schools are largely influenced by the governance and administrative leadership of the institutions. A significant finding from this study is that, in many instances, the education and health systems in private schools are better than those in government schools. This may be due to the leadership of the headmaster, who has more decision-making freedom than leaders in government schools.

Government schools often face strict financial policies that limit their ability to collaborate with local communities, whereas private schools have greater opportunities to engage in school development initiatives with parents and local stakeholders. When the managing committee of a private school is effective, it typically leads to positive outcomes. In contrast, government schools tend to have limitations in this area.

Governance among the government and non-government schools follow different path in the school. Such non-government schools are run by School Managing Committee (SMC) and they have some liberty in managing their own administration. On the other hand, the government schools do not have any SMC; rather, they are run by the governing rules of the DSHE through District and Upazila administration.

### **5.4. Reflection of school health service**

Other than the physical and psycho-social environment of the school, health services within the schools are nearly nonexistent. According to students, emergency health services are available in only a few schools, and when there are services, they are typically provided by unskilled personnel; as they mentioned in FGD: *"We have an assigned teacher who provides us necessary support, and tells us what to do"*. In another instance, teachers mentioned that, a school 'peon' who happened to be a drug seller provided first aid to the students (FGD source). Regular health check-ups in schools are also inadequate, leaving students perpetually at risk of health issues. During group discussions, teachers mentioned that when an emergency occurs, they send students to a nearby clinic. However, such referral is not a systematic approach but whenever possible teachers use their common sense and take necessary action. This information was obtained from the head teacher and teachers from Klis and FGDs. While many schools do have first aid facilities, there is often a lack of individuals trained to use them effectively. Furthermore, the absence of mid-day meal programmes forces students to buy unhealthy food from nearby shops or street vendors. All these factors contribute to a constant health risk for students in most schools across the country.

### **5.5. Socio-emotional environment in school**

A common practice in almost every school is to start the d3¥ with physical-gathering and a parade (PT) to promote students' physical and mental health. Most of the head teachers mentioned that necessary health sermons are given in these assemblies. However, beyond this initial activity, there is often little attention given to students' needs for ongoing sports facilities that support their physical and emotional well-being. Annual sports and cultural programmes are typically one-time events, which do not adequately promote the continuous development of students' mental health. Emotional safety is a function of teacher-student relationship. In general, there are very few teachers in a school who maintain good relationship with the students. As some students mentioned in their FGD that, *"Whenever, we face any personal problem we can talk to a particular teacher only. Most teachers do not give us such space."* The class schedule also does not allow necessary time to play, or outdoor physical movements necessary for healthy growth. Gender segregation within school and outside hampers free movement of the girls in

and outside school. Additionally, there is a significant shortage of sports equipment available for students in schools, and the equipment that does exist is often kept in storage, and is not accessible for use.

Although health education is part of the curriculum, but it is not included in examinations. Many teachers have indicated that most educational institutions in the country lack physical education teachers even. Besides this reason, no school is found to have regular monitoring system for checking on their students' various health conditions. As a result, despite good educational conditions in schools, there have been no significant initiatives focused on enhancing physical and mental health.

Feedback from teachers suggests that approximately 50% of schools maintain social connections with parents, local health workers, and law enforcement agencies to support students' psychosocial well-being. If the remaining schools also engage in these efforts, they could help protect all students from teasing, bullying, and environmental pollution. However, schools face numerous challenges in building these social connections, such as a lack of adequate manpower and essential funding.

### ***5.6. School community partnership***

A healthy school environment is achievable only when there is effective communication among teachers, parents, and the local community. Both the school and home play crucial roles in promoting a healthy lifestyle. Data indicates that almost all students engage in health practices at home, highlighting the importance of parental involvement. To emphasize this role, schools should conduct various health campaigns, including vaccination programmes and initiatives focused on adolescence and substance abuse. Girls receive more attention from parents and school authorities more than their boys' counterpart.

Students often believe their parents are aware of health matters, and if schools also recognize this issue, it will be easier to establish healthier schools. However, such social campaigns are relatively infrequent. This lack of initiative can often be attributed to a shortage of skilled personnel in schools and financial constraints.

### ***5.7. Reflections of physical environment of the school***

A review of the physical environments of the surveyed schools revealed that many do not meet the expectations of cleanliness in terms of pollutions, dirt, and tidiness. Students reported that more than half of the schools have polluted surroundings. The findings reveal several infrastructural deficiencies, including poor toilet conditions, the absence of effective systems for disposing of used sanitary napkins, inadequate canteen facilities, and insufficient safe common rooms for students. Teachers shared similar concerns about the physical environment. Additionally, their feedback regarding the health systems in the schools indicates that there are significant shortcomings that need to be addressed.

### ***5.8. Reflection about the content analysis***

The topic of health education and human welfare has been incorporated into the school curriculum as a separate subject, specifically in Bangladesh Global Studies, for all grades. Health education content is provided for students in grades 6 to 10. Additionally, health-related information is included in both social science and general science textbooks where relevant. A detailed content analysis of these books from grades VI to X has been conducted.

This analysis indicates that while several important health topics are mentioned across different classes, the coverage is inadequate. Discussions with curriculum experts revealed that not all of the textbooks on health

education have been developed with the necessary rigour. Some authors may have overlooked some details of the necessary section wherever necessary.

There was a lack of time and appropriate resources for writing the materials. The content analysis revealed that many books do not adequately mention the principles of health education set by the World Health Organization. It is important to note that topics such as road safety, drug addiction, suicide prevention, and children's sanitary health are often overlooked at all levels. Furthermore, there is little discussion about what to do in emergency situations, environmental health, or do-it-yourself health practices in these books.

To create healthier schools for students in Bangladesh, significant changes must be implemented across various aspects of these institutions. This includes improve ents in school infrastructure, opportunity for developing socio-emotional activities like, cultural activities, gamd, debates etc.; training for teachers and administrators, and enhancing the professionalism of staff. Additionally, it is crucial to reform the standard operating procedures (SOP) of the relevant Ministries. While a complete overhaul of the curriculum may not be necessary, a thoughtful adjustment of the health education curriculum is essential. Furthermore, adequate funding must be planned and allocated for the establishment of health-promoting schools.



## Recommendations

Based on the situation analysis of health education and students' well-being in secondary schools in Bangladesh, several valid and comprehensive recommendations can be drawn. These recommendations address the identified gaps in inter-ministerial coordination, policy implementation, school governance, health services, curriculum, partnership, and the physical and socio-emotional environment.

### *1. Establish Inter-Ministerial coordination and policy*

- **Establish a multi-sectoral coordination mechanism:** It is necessary to establish a formal, high-level coordination committee among the Ministries of Education, Health, and Social Welfare to integrate health promotion as shared responsibility and end the current lack of coordination.
- **Strengthen grassroots policy dissemination:** Implement a clear, simple, and effective strategy to ensure national policies (especially those concerning health, education, and well-being) reach the grassroots level (schools and field staff). Circulars alone are insufficient; mandatory training and awareness sessions should be conducted for policy implementers.
- **Review and reform standard operating procedures (SOP) dissemination:** There is problem with current operational procedure, therefore it is necessary to review and reform Ministerial Standard Operating Procedures (SOP) to support integration, and implement mandatory training to ensure national policies effectively reach grassroots implementers (schools/field staff).

### *2. Enhance School governance and leadership*

- **Increase autonomy for government school Headmaster:** Make arrangement to provide greater decision-making freedom and financial flexibility to headmasters in government schools to enable effective health and development initiatives.
- **Mandate and empower school managing committees (SMCs):** Create facilities to ensure SMCs are active, trained, and effectively engaged in overseeing student health and allocating necessary funds for it.
- **Foster school-community partnership:** Encourage and support all schools, especially government ones, to collaborate with parents, local communities, and health workers for student well-being.
- **Supportive supervision:** Provisions need to be created for supportive supervision and mentoring for well-being of teachers and students in terms of their physical, mental and socio-emotional issues.
- **Partnership:** In order to run the school health activities, every school should establish local partnership with the community, law enforcing agencies and local health clinics.

### *3. Improve health services and environment*

- **Establishing physical, mental and social environment:** Ensure all physical facilities in the school supportive to physical and mental health and well-being of the students.
- **Establish all kinds of physical and socio-emotional health services in the school:** Establish comprehensive physical and socio-emotional health services in all schools, ensuring the immediate availability of primary healthcare. These services should be managed and delivered under the direct supervision of a qualified and trained medical professional.
- **Mandate staff training and counseling:** Provide mandatory first-aid training for sufficient staff in every school and allocate resources to appoint trained counselors or guidance teachers to address mental health gaps. All trainings must be given on competency-based holistic aspects like, adolescent health, nutrition, hygiene, mental health, and environmental sustainability .

- **Introduce Mid-Day Meals and improve sanitation:** Launch a mid-day-meal programme for nutritious food access. Allocate funds to drastically improve physical environment, sanitation and WASH facilities, including disposal systems for sanitary napkins.
- **Stop consumption of unhealthy food consumption:** It is necessary to monitor and stop all kinds of unhealthy food intakes obtained from within and outside school premise.

#### ***4. Socio-emotional environment and physical activity***

- **Prioritize continuous physical activity:** Restructure the class schedule and school activities to allow for necessary time for play and outdoor physical movements throughout the week, beyond the initial assembly and one-time annual events. These physical activities should be linked to life-skills objectives such as resilience, teamwork and self-regulation. This is to enhance the socio-emotional well-being of students.
- **Address shortage of physical education (PE) staff and equipment:** Ensure the appointment of qualified physical education teachers in all schools. Furthermore, allocate funds for buying sports equipment and make them accessible to students for regular use, rather than keep them in storage.
- **Tackle psycho-social issues:** Schools should actively work to protect all students from teasing, bullying, and mental harassment by building social connections with external agencies and providing effective supervision. More so, parents and caregivers' awareness and engagement programmes should be conducted regularly to establish understanding of adolescent mental health needs, early signs of distress and healthy parenting practices.

#### ***5. Curriculum and content reform***

- **Revise health education curriculum:** Conduct a thoughtful and rigorous adjustment of the health education curriculum and related content in textbooks (Bangladesh Global Studies, Social Science, and General Science) to ensure adequate coverage and depth in the field of nutrition, mental health, tobacco prevention.
- **Ensure content quality:** Engage qualified curriculum experts and authors with expertise in health education and students' well-being to develop the materials, ensuring they align with established principles (e.g., WHO guidelines for health education).
- **Integrate overlooked topics:** Ensure that the curriculum explicitly and adequately covers critical, often overlooked topics, including road safety, drug addiction, suicide prevention, children's sanitary health, emergency health practices, environmental health, and do-it-yourself health practices.

#### ***6. Resource allocation***

- **Ensure adequate financial allocation:** Crucially, adequate and specific funding must be planned and allocated by the relevant Ministries for the establishment and continuous operation of health-promoting schools, covering infrastructure, training, staffing, and health services.

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## Annexure Tables

Table 4.1. Class wise KAP means score of the students.

| Classes | Knowledge<br>(Max. score is 30) | Attitude<br>(Max. score is 66) | Practice<br>(Max. score is 30) |
|---------|---------------------------------|--------------------------------|--------------------------------|
| Six     | 12.56                           | 48.16                          | 23.18                          |
| Seven   | 12.82                           | 51.52                          | 25.08                          |
| Eight   | 12.97                           | 51.29                          | 24.30                          |
| Nine    | 12.50                           | 50.24                          | 23.89                          |
| Ten     | 12.80                           | 51.77                          | 24.13                          |

Table 4.2. Annex Tables on Content Analysis

The Evaluation Checklist for Health and Well-being Contents in the Textbooks

Title of the textbook/subject: Bangladesh and Global Studies (BGS)

| 1. SEL - Socio-Emotional Learning |                                           |          | Presence/evidence (ranges from 1 to 5) |            |            |         |
|-----------------------------------|-------------------------------------------|----------|----------------------------------------|------------|------------|---------|
|                                   | Topic or content                          | Class VI | Class VII                              | Class VIII | Class IX-X | Comment |
| 1                                 | Emotion and stress management             |          |                                        |            |            |         |
| 2                                 | Communication/negotiation / refusal skill | 3        | 3                                      | 3          | 3          |         |
| 3                                 | Problem-solving skills                    | 5        | 5                                      | 5          | 5          |         |
| 4                                 | Decision-making skills                    | 5        | 5                                      | 5          | 5          |         |
|                                   | Total percentage of coverage              | 65%      | 65%                                    | 65%        | 65%        |         |

| 2. HHL - Health and Healthy Lifestyle |                                       | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
|---------------------------------------|---------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                       | Topic or content                      | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                     | Food, nutrition & contamination       |                                        |           |            |            |         |
| 2                                     | First Aid                             |                                        |           |            |            |         |
| 3                                     | Immunization                          |                                        |           |            |            |         |
| 4                                     | Personal hygiene & oral health        |                                        |           |            |            |         |
| 5                                     | Physical activity, sports and fitness |                                        |           |            |            |         |
| 6                                     | School health service                 |                                        |           |            |            |         |
| 7                                     | Games and sports                      |                                        |           |            |            |         |
|                                       | Total percentage of coverage          |                                        |           |            |            |         |

| 3. PC - Prevention of Circumstances |                                     |                                        |           |            |            |         |
|-------------------------------------|-------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                     |                                     | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
|                                     | Topic or content                    | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                   | Mental health                       |                                        |           |            |            |         |
| 2                                   | Road safety /accidents              |                                        |           |            | 5          |         |
| 3                                   | Violence & bullying prevention      |                                        |           |            |            |         |
| 4                                   | Suicide prevention                  |                                        |           |            |            |         |
| 5                                   | Drug/alcohol/tobacco use prevention |                                        |           | 5          |            |         |
| 6                                   | Infectious disease prevention       |                                        |           |            |            |         |
| 7                                   | Fire safety                         |                                        |           |            |            |         |
| 8                                   | Non-communicable disease            |                                        |           |            |            |         |
|                                     | Total percentage of coverage        |                                        |           | 12.5%      | 12.5%      |         |

| 4. RH - Reproductive Health  |                                     |                                        |           |            |            |         |
|------------------------------|-------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                              |                                     | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
| Topic or content             |                                     | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                            | Pubertal change/reproductive health |                                        |           |            |            |         |
| 2                            | STD & HIV transmission              |                                        |           |            |            |         |
| 3                            | Menstrual health management         |                                        |           |            |            |         |
| Total percentage of coverage |                                     |                                        |           |            |            |         |

| 5. EHS - Environmental Health and Sustainability |                                       |                                        |           |            |            |         |
|--------------------------------------------------|---------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                                  |                                       | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
| Topic or content                                 |                                       | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                                | Environment pollution/ sustainability | 5                                      | 5         | 5          | 5          |         |
| 2                                                | Natural disaster preparedness         |                                        | 5         | 5          |            |         |
| 3                                                | Environmental health                  |                                        | 5         |            | 3          |         |
| Total percentage of coverage                     |                                       | 33.33%                                 | 100%      | 66.67%     | 53.33%     |         |

| 6. SCI - Socio Cultural Issues |                                         |                                        |           |            |            |         |
|--------------------------------|-----------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                |                                         | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
| Topic or content               |                                         | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                              | Equity and inclusion/gender equality    | 5                                      | 5         | 5          | 5          |         |
| 2                              | Respect for diversity                   | 5                                      | 5         | 5          | 5          |         |
| 3                              | Human rights                            | 5                                      | 5         | 5          | 5          |         |
| 4                              | Internet addiction/Safe use of internet |                                        |           | 1          |            |         |
| Total percentage of coverage   |                                         | 75%                                    | 75%       | 80%        | 75%        |         |

**Title of the textbook/subject: Physical Health and Education (PHE)**

| <b>1. SEL - Socio-Emotional Learning</b> |                                         | Presence/evidence (ranges from <b>1</b> to <b>5</b> ) |           |            |            |         |
|------------------------------------------|-----------------------------------------|-------------------------------------------------------|-----------|------------|------------|---------|
|                                          | Topic or content                        | Class VI                                              | Class VII | Class VIII | Class IX-X | Comment |
| 1                                        | Emotion and stress management           | 1                                                     |           |            | 5          |         |
| 2                                        | Communication/negotiation/refusal skill | 5                                                     | 5         | 5          | 5          |         |
| 3                                        | Problem solving skills                  | 5                                                     | 5         | 5          | 5          |         |
| 4                                        | Decision making skills                  | 5                                                     | 5         | 5          | 5          |         |
|                                          | Total percentage of coverage            | 80%                                                   | 75%       | 75%        | 100%       |         |

| <b>2. HHL - Health and Healthy Lifestyle</b> |                                       | Presence/evidence (ranges from <b>1</b> to <b>5</b> ) |           |            |            |         |
|----------------------------------------------|---------------------------------------|-------------------------------------------------------|-----------|------------|------------|---------|
|                                              | Topic or content                      | Class VI                                              | Class VII | Class VIII | Class IX-X | Comment |
| 1                                            | Food, nutrition & contamination       | 5                                                     | 1         |            | 5          |         |
| 2                                            | First Aid                             | 5                                                     | 5         | 5          |            |         |
| 3                                            | Immunization                          | 5                                                     |           |            | 1          |         |
| 4                                            | Personal hygiene & oral health        | 5                                                     | 5         |            | 5          |         |
| 5                                            | Physical activity, sports and fitness | 5                                                     | 5         | 5          | 5          |         |
| 6                                            | School health service                 |                                                       |           |            | 5          |         |
| 7                                            | Games and sports                      | 5                                                     | 5         | 5          | 5          |         |
|                                              | Total percentage of coverage          | 85.71%                                                | 60%       | 42.86%     | 74.29%     |         |

| <b>3. PC - Prevention of Circumstances</b> |                                     | Presence/evidence (ranges from <b>1</b> to <b>5</b> ) |           |            |            |         |
|--------------------------------------------|-------------------------------------|-------------------------------------------------------|-----------|------------|------------|---------|
|                                            | Topic or content                    | Class VI                                              | Class VII | Class VIII | Class IX-X | Comment |
|                                            | Mental health                       | 5                                                     | 5         |            | 5          |         |
| 2                                          | Road safety /accidents              |                                                       |           |            | 5          |         |
| 3                                          | Violence & bullying prevention      |                                                       |           |            |            |         |
| 4                                          | Suicide prevention                  |                                                       |           |            |            |         |
| 5                                          | Drug/alcohol/tobacco use prevention |                                                       | 5         |            | 5          |         |
| 6                                          | Infectious disease prevention       | 5                                                     |           |            |            |         |
| 7                                          | Fire safety                         |                                                       |           |            |            |         |
| 8                                          | Non-communicable disease            |                                                       |           | 1          | 3          |         |
|                                            | Total percentage of coverage        | 25%                                                   | 25%       | 2.5%       | 45%        |         |

| <b>4. RH - Reproductive Health</b> |                                     | Presence/evidence (ranges from <b>1</b> to <b>5</b> ) |           |            |            |         |
|------------------------------------|-------------------------------------|-------------------------------------------------------|-----------|------------|------------|---------|
|                                    | Topic or content                    | Class VI                                              | Class VII | Class VIII | Class IX-X | Comment |
| 1                                  | Pubertal change/reproductive health | 5                                                     | 5         | 5          | 5          |         |
| 2                                  | STD & HIV transmission              | 1                                                     |           |            | 5          |         |
| 3                                  | Menstrual health management         | 1                                                     |           |            |            |         |
|                                    | Total percentage of coverage        | 46.67%                                                | 33.33%    | 33.33%     | 66.67%     |         |

| 5. EHS - Environmental Health and Sustainability |                                          |                                                |           |            |            |         |
|--------------------------------------------------|------------------------------------------|------------------------------------------------|-----------|------------|------------|---------|
|                                                  |                                          | Presence /evidence (ranges from <b>1</b> to 5) |           |            |            |         |
|                                                  | Topic or content                         | Class VI                                       | Class VII | Class VIII | Class IX-X | Comment |
| 1                                                | Environment pollution/<br>sustainability |                                                |           |            |            |         |
| 2                                                | Natural disaster preparedness            |                                                |           |            |            |         |
| 3                                                | Environmental health                     |                                                |           |            |            |         |
|                                                  | Total percentage of coverage             |                                                |           |            |            |         |

| 6. SCI - Socio Cultural Issues |                                         |                                               |           |            |                   |                  |
|--------------------------------|-----------------------------------------|-----------------------------------------------|-----------|------------|-------------------|------------------|
|                                |                                         | Presence/evidence (ranges from <b>1</b> to 5) |           |            |                   |                  |
|                                | Topic or content                        | Class VI                                      | Class VII | Class VIII | Class <b>IX-X</b> | Comment          |
|                                | Equity and inclusion/gender equality    | 5                                             | 5         | 5          | 5                 | Class-7,8 images |
| 2                              | Respect for diversity                   |                                               |           |            |                   |                  |
| 3                              | Human rights                            |                                               |           |            |                   |                  |
| 4                              | Internet addiction/Safe use of internet |                                               |           |            |                   |                  |
|                                | Total percentage of coverage            | 25%                                           | 25%       | 25%        | 25%               |                  |

**Title of the textbook/subject: Science**

| 1. SEL - Socio-Emotional Learning |                                            | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
|-----------------------------------|--------------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                   | Topic or content                           | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                 | Emotion and stress management              |                                        |           |            | 1          |         |
| 2                                 | Communication /negotiation / refusal skill | 5                                      | 5         | 5          | 5          |         |
| 3                                 | Problem solving skills                     | 5                                      | 5         | 5          | 5          |         |
| 4                                 | Decision making skills                     | 5                                      | 5         | 5          | 5          |         |
|                                   | Total percentage of coverage               | 75%                                    | 75%       | 75%        | 80%        |         |

| 2. HHL - Health and Healthy Lifestyle |                                       | Presence /evidence (ranges from 1 to 5) |           |            |            |         |
|---------------------------------------|---------------------------------------|-----------------------------------------|-----------|------------|------------|---------|
|                                       | Topic or content                      | Class VI                                | Class VII | Class VIII | Class IX-X | Comment |
| 1                                     | Food, nutrition & contamination       | 5                                       | 1         | 5          | 5          |         |
| 2                                     | First Aid                             |                                         |           |            |            |         |
| 3                                     | Immunization                          |                                         |           |            |            |         |
| 4                                     | Personal hygiene & oral health        | 5                                       | 1         |            |            |         |
| 5                                     | Physical activity, sports and fitness |                                         |           |            | 5          |         |
| 6                                     | School health service                 |                                         |           |            |            |         |
| 7                                     | Games and sports                      |                                         |           |            |            |         |
|                                       | Total percentage of coverage          | 28.57%                                  | 5.71%     | 14.29%     | 28.57%     |         |

| 3. PC - Prevention of Circumstances |                                     |                                        |           |            |            |         |
|-------------------------------------|-------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                     |                                     | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
|                                     | Topic or content                    | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                   | Mental health                       |                                        |           |            | 3          |         |
| 2                                   | Road safety /accidents              |                                        |           |            |            |         |
| 3                                   | Violence & bullying prevention      |                                        |           |            |            |         |
| 4                                   | Suicide prevention                  |                                        |           |            |            |         |
| 5                                   | Drug/alcohol/tobacco use prevention |                                        |           |            | 5          |         |
| 6                                   | Infectious disease prevention       |                                        | 5         |            |            |         |
| 7                                   | Fire safety                         |                                        |           |            |            |         |
| 8                                   | Non-communicable disease            |                                        | 3         | 5          | 5          |         |
|                                     | Total percentage of coverage        | 2.5%                                   | 20%       | 12.5%      | 32.5%      |         |

| 4. RH - Reproductive Health  |                                     |                                        |           |            |            |         |
|------------------------------|-------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                              |                                     | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
| Topic or content             |                                     | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                            | Pubertal change/reproductive health |                                        |           |            | 5          |         |
| 2                            | STD & HIV transmission              |                                        |           |            | 4          |         |
| 3                            | Menstrual health management         |                                        |           |            | 1          |         |
| Total percentage of coverage |                                     |                                        |           |            | 66.67%     |         |

| 5. EHS - Environmental Health and Sustainability |                                          |                                        |           |            |            |         |
|--------------------------------------------------|------------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                                  |                                          | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
| Topic or content                                 |                                          | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                                | Environment pollution/<br>sustainability | 5                                      | 5         | 5          | 5          |         |
| 2                                                | Natural disaster preparedness            |                                        |           | 1          | 5          |         |
| 3                                                | Environmental health                     |                                        | 2         |            | 5          |         |
| Total percentage of coverage                     |                                          | 33.33%                                 | 46.67%    | 40%        | 100%       |         |

| 6. SCI - Socio Cultural Issues |                                         |                                        |           |            |            |         |
|--------------------------------|-----------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                |                                         | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
| Topic or content               |                                         | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                              | Equity and inclusion/gender equality    | 5                                      | 5         | 5          | 5          |         |
| 2                              | Respect for diversity                   |                                        |           |            |            |         |
| 3                              | Human rights                            |                                        |           |            | 5          |         |
| 4                              | Internet addiction/Safe use of internet |                                        |           |            |            |         |
| Total percentage of coverage   |                                         | 25%                                    | 25%       | 25%        | 50%        |         |

Table 4.3. Health supporting services available in the school as perceived by the students.

|                                                                                                                 | Govt. school | Non-govt. school | All school |
|-----------------------------------------------------------------------------------------------------------------|--------------|------------------|------------|
| 1. Conduct regular health checkup                                                                               | 30.8%        | 35.6%            | 33.6%      |
| 2. Parents invited in health checkup program                                                                    | 17.5%        | 34.3%            | 26.9%      |
| 3. Parents are informed about such program                                                                      | 51.2%        | 51.9%            | 52.0%      |
| 4. Parents encourage health practice at home                                                                    | 94.3%        | 91.2%            | 92.8%      |
| 5. Connected with local clinic for health service                                                               | 44.5%        | 49.8%            | 47.8%      |
| 6. External health workers are involved in health checkup                                                       | 37.9%        | 39.3%            | 38.9%      |
| 7. School involved in health campaign                                                                           | 34.6%        | 40.6%            | 37.8%      |
| 8. School has emergency measures for students' health School has emergency arrangement for accidental situation | 41.2%        | 44.8%            | 43.0%      |
| 9. Have knowledge about health service provision                                                                | 73.9%        | 71.1%            | 72.1%      |
| 10. Take part in immunization program                                                                           | 78.7%        | 79.1%            | 79.3%      |
| 11. Knowledge about the sources of mental support                                                               | 53.6%        | 64.9%            | 59.6%      |
| 12. School distribute posters of non-communicable diseases                                                      | 27.0%        | 25.5%            | 26.2%      |
| 13. Workshop on adolescence or drug addiction arranged                                                          | 29.2%        | 18.3%            | 23.0%      |
| 14. Children with disability get support from the school                                                        | 17.2%        | 17.7%            | 17.1%      |
| 15. The class is crowded                                                                                        | 47.1%        | 53.4%            | 50.4%      |
| 16. Parents know human health problems well                                                                     | 54.1%        | 54.9%            | 54.0%      |
| 17. School situated in dirty and noisy place                                                                    | 21.7%        | 12.4%            | 16.9%      |
| 17. Family is solvent for taking health care                                                                    | 85.2%        | 81.4%            | 83.3%      |

1. School health service activities: 9, 10, 11,13, 14, 16,
2. School-community involvement: 15, 18, 20,21,
3. Students' knowledge about service provision: 17, 19,
4. School environment: 23,25,

Annexure Table 4.4. Perception about Health Education and National Education Policies among teachers distributed by gender. ( in %)

| Name of Policy            | Response   | Male | Female | Total |
|---------------------------|------------|------|--------|-------|
| Health Education Policy   | Yes        | 59.1 | 64.9   | 61.2  |
|                           | No         | 8.3  | 6.8    | 7.8   |
|                           | Don't know | 32.6 | 28.4   | 31.3  |
| National Education Policy | Yes        | 52.3 | 58.1   | 54.4  |
|                           | No         | 37.9 | 32.4   | 35.9  |
|                           | Don't know | 9.8  | 9.5    | 9.7   |

## Content Analysis Checklist

### Health and Wellbeing Content Evaluation Checklist for the Textbook

#### Instruction:

The following checklist can be used for any textbook of grades VI through X. In order to evaluate the content please read the chapter and identify thematic contents in terms of text, diagram or picture. The health and well-being contents are divided into six main themes and several sub-themes. In all, 29 sub-themes are identified under six main themes. The main themes and their corresponding sub-themes are distributed in the following checklist table. The main themes are:

1. **Socio-emotional learning (SEL):** It is an educational method that integrates the development of social and emotional skills into school curricula.
2. **Health and healthy lifestyle (HHL):** A healthy lifestyle is a valuable resource for reducing the incidence and impact of health problems, for recovery, for coping with life stressors, and for improving quality of life.
3. **Prevention of circumstances (PC):** This can be defined as a state of readiness to respond to a disaster, crisis, or any other type of emergency that is injurious to health, hygiene or mental state.
4. **Reproductive health (RH):** This is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.
5. **Environmental health and sustainability (EHS):** It comprises those aspects of human health, including quality of life, that are determined by physical, chemical, biological, social and psychosocial factors in the environment.
6. **Socio-cultural issues (SCI):** Sociocultural issues refer to differences between groups of people relating to the social class and culture in which they live.

For analyses of the health and well-being content in the textbook, a five-point indicator scale is proposed. The five-point indicators are:

|                     |   |
|---------------------|---|
| Fully evident       | 5 |
| Mostly evident      | 4 |
| Largely evident     | 3 |
| Partially evident   | 2 |
| Very little evident | 1 |

Identify the content and sub-contents, then judge their amounts in terms of given indicators i.e., points and put it in the numbers in the appropriate cell under each main theme and sub-theme.

The evaluation grid is given on the following page.

## The Evaluation Checklist for HPS Contents in the Textbook

Title of the textbook/subject: ..... Grade: .....

| 7. SEL - Socio-Emotional Learning |                                         | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
|-----------------------------------|-----------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                   | Topic or content                        | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                 | Emotion and stress management           |                                        |           |            |            |         |
| 2                                 | Communication/negotiation refusal skill |                                        |           |            |            |         |
| 3                                 | Problem solving skills                  |                                        |           |            |            |         |
| 4                                 | Decision making skills                  |                                        |           |            |            |         |
|                                   | Total percentage of coverage            |                                        |           |            |            |         |

| 8. HHL - Health and Healthy Lifestyle |                                       | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
|---------------------------------------|---------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                       | Topic or content                      | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                     | Food, nutrition & contamination       |                                        |           |            |            |         |
| 2                                     | First Aid                             |                                        |           |            |            |         |
| 3                                     | Immunization                          |                                        |           |            |            |         |
| 4                                     | Personal hygiene & oral health        |                                        |           |            |            |         |
| 5                                     | Physical activity, sports and fitness |                                        |           |            |            |         |
| 6                                     | School health service                 |                                        |           |            |            |         |
| 7                                     | Games and sports                      |                                        |           |            |            |         |
|                                       | Total percentage of coverage          |                                        |           |            |            |         |

| 9. PC - Prevention of Circumstances |                                     |                                        |           |            |            |         |
|-------------------------------------|-------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                     |                                     | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
|                                     | Topic or content                    | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                   | Mental health                       |                                        |           |            |            |         |
| 2                                   | Road safety /accidents              |                                        |           |            |            |         |
| 3                                   | Violence & bullying prevention      |                                        |           |            |            |         |
| 4                                   | Suicide prevention                  |                                        |           |            |            |         |
| 5                                   | Drug/alcohol/tobacco use prevention |                                        |           |            |            |         |
| 6                                   | Infectious disease prevention       |                                        |           |            |            |         |
| 7                                   | Fire safety                         |                                        |           |            |            |         |
| 8                                   | Non-communicable disease            |                                        |           |            |            |         |
|                                     | Total percentage of coverage        |                                        |           |            |            |         |
|                                     |                                     |                                        |           |            |            |         |

| 10. RH - Reproductive Health |                                     |                                        |           |            |            |         |
|------------------------------|-------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                              |                                     | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
|                              | Topic or content                    | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                            | Pubertal change/reproductive health |                                        |           |            |            |         |
| 2                            | STD & HIV transmission              |                                        |           |            |            |         |
| 3                            | Menstrual health management         |                                        |           |            |            |         |
|                              | Total percentage of coverage        |                                        |           |            |            |         |

| <b>11. EHS - Environmental Health and Sustainability</b> |                                          |                                                |           |            |            |         |
|----------------------------------------------------------|------------------------------------------|------------------------------------------------|-----------|------------|------------|---------|
|                                                          |                                          | Presence /evidence (ranges from <b>1</b> to 5) |           |            |            |         |
|                                                          | Topic or content                         | Class VI                                       | Class VII | Class VIII | Class IX-X | Comment |
| 1                                                        | Environment pollution/<br>sustainability |                                                |           |            |            |         |
| 2                                                        | Natural disaster preparedness            |                                                |           |            |            |         |
| 3                                                        | Environmental health                     |                                                |           |            |            |         |
|                                                          | Total percentage of coverage             |                                                |           |            |            |         |

| <b>12. SCI - Socio Cultural Issues</b> |                                                |                                        |           |            |            |         |
|----------------------------------------|------------------------------------------------|----------------------------------------|-----------|------------|------------|---------|
|                                        |                                                | Presence/evidence (ranges from 1 to 5) |           |            |            |         |
|                                        | Topic or content                               | Class VI                               | Class VII | Class VIII | Class IX-X | Comment |
| 1                                      | Equity and inclusion/gender<br>equality        |                                        |           |            |            |         |
| 2                                      | Respect for diversity                          |                                        |           |            |            |         |
| 3                                      | Human rights                                   |                                        |           |            |            |         |
| 4                                      | Internet addiction/Safe use of the<br>internet |                                        |           |            |            |         |
|                                        | Total percentage of coverage                   |                                        |           |            |            |         |

## Glossary

**Community:** School and local communities

**Component (of a standard):** A thematic, action-oriented statement that must be implemented to achieve the standard. Some components contain additional statements that describe quality implementation of the component.

**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 in accordance with the WHO guideline on school health services.

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

**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

**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, social and life effects of education, including school completion and employment

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

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

**Health education:** Any combination of learning experiences designed to help individuals and communities improve their health by increasing their 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 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 development of knowledge and skills that enable action 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". 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 continuing 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 itself as a safe, healthy setting for teaching, learning and working. The global standards and indicators are applicable to any whole-school approach to health, even if the term "HPS" is not used (e.g. comprehensive school health, healthy learning environment, *ecole en sante*, *escuela para la salud*).

**Implementation:** Conduct of a specified set of activities to establish or put in place a programme 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. 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.

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

- 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 the activities conducted to achieve the objectives of a programme, including what is done and how well it is done;
- Output indicator: used to monitor the immediate results of various processes in terms of service access, availability, quality and safety;
- Outcome indicator: used to monitor the intermediate results of a programme that are measurable at population level; and
- Impact indicator: used to evaluate the long-term outcomes to which programmes are designed to contribute affect, including decreased mortality and morbidity.

**Inter-sectoral collaboration:** A working relation between two or more sectors to achieve, in the context of HPS, health and education outcomes in an effective, efficient, sustainable manner

**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 (NGOs), faith-based organizations, private enterprises, community health services and community groups such as youth groups and providers of organized sports, arts and other culture.

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

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

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

**School community:** All school staff, including teachers, school 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.

**Social-emotional learning:** Specific elements 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, and make responsible decisions ...". 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 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.

**Standard statement:** The overarching descriptor of a global standard.

**Subnational:** Political- administrative unit that operates at the level of a state, region, province, municipality, district or zone. Countries may have different levels of school governance.

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

**Well-being:** A physical, emotional and social state "in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community". Well-being is defined as five interconnected domains including good health and optimum nutrition; connectedness, positive values, and contribution to society; safety and a supportive environment; learning, competence, education, skills, and employability; and agency and resilience.

**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". 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.

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

Source: Making every school a health-promoting school, Global Standards and Indicators, UNESCO & **WHO**, 2021





Sustainable  
Development  
Goals