Revitalizing school health programmes and health-promoting schools in the South-East Asia Region

South-East Asia is home to about 627 million children under the age of 18 years, or approximately 36% of the total population of 1.82 billion. In the South-East Asia Region, the health and well-being of 362 million adolescent (aged 10–19 years) boys and girls will be the key to national development in Member States as they progress towards achieving the Sustainable Development Goals. About 184 580 000 pupils who are enrolled in primary education in the Region today are affected by the closure of schools due to COVID-19.

The Regional Office and Member States recognized the need to revitalize comprehensive health-promoting schools to support Member States to prepare schools for recovery, restore health-promotion activities, and scale up the health-promoting schools initiative introduced since 1995 and meet the Global Standards for Health Promoting Schools launched in 2021. It is imperative to recognize that schools are diverse (public, private, monastic schools, faith-based education, non-formal education for migrant children, special education for children with special needs). These diversities need to take into account the particularities of pre-existing health systems in the varying sociopolitical landscapes of countries. Cohesion via intersectoral collaboration between the health, education and other ministries will help further equitable access to health education, strengthen health literacy and achieve improved health and well-being in school-aged children.

This background paper serves as evidence of the need to revitalize health-promoting schools in the South-East Asia Region and support the resolution to take concrete actions.

The agenda was introduced and discussed at the High-Level Preparatory Meeting held in July 2021. The HLP Meeting, after due deliberations, made the following recommendations for action to be taken:

Action by Member States

(1) Review the Draft Resolution on “Revitalizing school health and health-promoting schools in the South-East Asia Region” and provide feedback/inputs to the Secretariat.

Action by WHO

(1) Prepare the Working Paper on the Agenda item and submit it to the Seventy-fourth Session of the Regional Committee in September for its consideration.
To build upon the new global initiative on health-promoting schools and the urgent imperative of doing so to secure the health of future generations, Member States would like to call for commitment to the initiative and strong collaboration between the health and education sectors at the policy level, that will lead to school and community engagement at the school level.

The Regional Office will:

(1) develop a regional roadmap to scale up school health programmes and health-promoting school practices to meet the Global Standards for Health Promoting Schools and strengthen collaboration between the health and education sectors.

(2) recommend all possible mitigation measures (such as hygiene, sanitization, respiratory etiquette and physical distancing during the COVID-19 pandemic and other measures in different types of public health emergencies and outbreaks in the future) to be implemented in all schools.

This Working Paper along with the resolution proposed by Thailand and the HLP Meeting recommendations are submitted to the Seventy-fourth Session of the WHO Regional Committee for South-East Asia for its consideration and decision.
Background

1. Children and adolescents spend most of their productive years in schools as part of growing up. South Asia is home to about 627 million children under the age of 18 years—approximately 36% of the total population of 1.82 billion. The health and well-being of 362 million adolescent (10–19 years) boys and girls in the South-East Asia Region will be key to the national development of Member States as they progress towards achievement of the Sustainable Development Goals. Although adolescents are generally considered healthy, there is significant mortality and morbidity in this age group. There were an estimated 1.7 million deaths among adolescents in 2015 in the Region. The leading causes of mortality include self-harm (suicide), road injury and maternal mortality (among women aged 15–19 years). Significant morbidity is reported among adolescents in the Region due to self-harm, iron deficiency anaemia, depressive disorders, road traffic injuries and diarrhoeal diseases. Among the world’s children aged 13–15 years who use various forms of tobacco, over a third (34% or 14.8 million) are in the South-East Asia Region.

2. Schools and school health programmes play important roles in reducing these risks and childhood mortality, nurturing healthy behaviour and providing a protective environment for children and adolescents. Enrolment in primary education (Gross enrolment ratio) is varied in South-East Asian countries. As of September 2020, it was as follows: Bangladesh (116%), Bhutan (106%), DPR Korea (89%), India (97%), Indonesia (106%), Maldives (98%), Myanmar (112%), Nepal (142%), Sri Lanka (100%), Thailand (101%), and Timor-Leste (112%). The total number of pupils in primary education in these countries is 184 580 119. Traditionally, school health programmes are targeted to improve students’ health and comprise health education, health services and the environment. Schools provide important interventions that address nutrition issues (stunting, wasting, micronutrient deficiencies and obesity), dental caries, drowning, infectious diseases due to poor sanitation and hygiene, sexual and reproductive diseases and unwanted pregnancy through life-skills education and human papillomavirus (HPV) immunization for girls, and risk factors for noncommunicable disease through prohibition of tobacco and substance use. They also provide psychosocial support and promote physical activity and healthy behaviours. Schools also have the potential to provide supportive environments and offer life-skills development and linkages to communities.

3. In 1995, WHO launched its Global School Health Initiative, introducing the Health Promoting School (HPS) approach, which strengthens a school’s capacity to promote healthy learning, living and working conditions, in conjunction with teachers and school staff and parents, ensuring a continuing enabling environment from school to the home and community. It incorporates school health education, health services along with school/community projects and outreach, health promotion programmes for staff, nutrition, food safety and a healthy diets programme, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion. It is a comprehensive approach that promotes both health and education, where health and educational officials, teachers, teachers’

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a Gross enrolment ratio is the ratio of total enrolment, regardless of age, to the population of the age group that officially corresponds to the level of education shown. Gross enrolment ratios indicate the capacity of each level of the education system, but a high ratio may reflect a substantial number of overage children enrolled in each grade because of repetition or late entry rather than a successful education system. Enrolment indicators are based on annual school surveys, but do not necessarily reflect actual attendance or drop-out rates during the year.
associations, students, parents and community leaders play roles in making the school a healthy place. WHO, UNESCO and UNICEF jointly launched the initiative and developed a framework based on four pillars – health-related school policies, safe learning environment, skill-based health education, school-based health and nutritional services.

4. In 2015, the WHO Regional Office for South-East Asia organized an International Conference on health-promoting schools: achieving education and health outcomes, in Bangkok, Thailand. The Conference identified the challenges and successes in implementing comprehensive health promotion in schools. Delegates from the health and education sectors in South-East Asia, the Western Pacific, and the Middle East and African regions, along with United Nations agencies, international nongovernment organizations and school health experts from academia deliberated and discovered that a difference in the focus of implementation is dependent on resources. In low- and middle-income countries, health programmes such as sanitation and hygiene, immunization, school lunch, micronutrient supplementation, health screening (weight and height measurement, eyesight and hearing) and deworming are very important for students’ health. In high-resource countries, prevention of noncommunicable diseases (NCDs) such as promoting physical activity; healthy diets, particularly an increase fruits and vegetable intake, and control of sugar and fat intake; prevention of tobacco use; and provision of oral health and dental care are practised more widely. School staff and teachers were not identified as playing a central role in health promotion, except in examples from Thailand, the Philippines, Lao People’s Democratic Republic and Cambodia. Investment in school health activities relied on health programmes and donor agencies. A strong need to optimize opportunities to implement a holistic approach to improve children’s and adolescents’ health was demonstrated with the renewal of commitments to scale up HPS in all schools. This would ensure health equity and equal opportunities for education and need a monitoring system as well as strengthening multisectoral collaboration within and across ministries. Special attention was needed to address mental health issues, violence, safety, injuries, climate change, and related challenges such as disasters, conflict and humanitarian crises, and equity for children from a low socioeconomic background and from geographically isolated and disadvantaged areas.

5. In 2018, WHO and UN partners released the International guidance on comprehensive sexuality education (CSE), which plays a central role in preparing young people for a safe, productive and fulfilling life in a world where HIV and AIDS, sexually transmitted infections (STIs), unintended pregnancies, gender-based violence (GBV) and gender inequality still pose serious risks to their well-being. Countries are increasingly acknowledging the importance of equipping young people with the knowledge and skills to make responsible choices in their lives, particularly in a context where they have greater exposure. Subsequently, the Regional Office developed the Regional strategic guidance for adolescent health (2018–2022), providing a way forward for countries to build upon the existing national adolescent health plans and adapt strategic elements from the Global accelerated action for the health of adolescents (AA-HA) guidance and broaden comprehensive services through a multisectoral approach.

6. In 2020, the Regional Office developed GenNext: exit NCDs intervention tool for prevention of NCD risk factors among schoolchildren for prevention of NCD risk factors targeted at children aged 5–15 years with a facilitator’s guide for teachers. This intervention tool is to be implemented within the ambit of the health-promoting school initiative. These activities are designed to motivate students to take the corrective measures needed to lead a healthy life.
Teachers are a vital component in implementing the intervention tool with the help of the facilitator’s manual. The manual contains six modules under two major sections, i.e. promotion of a healthy lifestyle and prevention of unhealthy behaviour.

7. In 2019, WHO, UNESCO, UNICEF and inter-agency partners worked together to transform fragmented school health services to generate better systems and structures to provide a holistic approach to health-promoting schools, inclusive of digital learning, involvement of parents, teachers, staff and, to some extent, the communities where children live.

8. The Global standards for health promoting schools⁶ and Implementation guidance⁹ were developed collaboratively by WHO, UNESCO, UNICEF and expert groups to support health and education. Investment in health is called for in school settings. WHO and UNESCO have launched a new initiative “Making Every School a Health Promoting School” on 22 June 2021¹⁰ led by the Director-General of WHO and UNESCO. Thailand⁸ has been one of the leading countries of this initiative and expressed commitment during the global launch along with the voices of teachers and students from India, Botswana and Egypt during the session. Hundreds of participants joined in support of this initiative. The initiative is expected to serve over 2.3 billion school-age children and will contribute to WHO’s Thirteenth General Programme of Work target of achieving “One billion lives made healthier” by 2023 and to the achievement of the Sustainable Development Goals in the field of education and health.

9. The ongoing COVID-19 pandemic (ongoing since 202) and public health measures, particularly restriction of movement and physical distancing, continues to affect the health and well-being of all populations, especially school-going children and adolescents. All children of all ages, and in all countries, have been affected by the shift to learning on digital devices and e-learning platforms at home, as a result of restrictions due to the pandemic, as well as the socioeconomic impacts on their families. This is a universal crisis in education, and the effects on child development and other health-related effects will be lifelong. School reopening¹¹ will need to be rigorous to prevent and prepare for a resurgence in COVID-19 or similar public health crisis. Schools that promote health in all its dimensions will be able to meet these challenges effectively. After this crisis, governments around the world will need to reassess learning systems to better confront the challenges.

10. The Regional Office and Member States recognized the need to revitalize comprehensive health-promoting schools to support Member States to prepare schools for recovery, restore health promotion activities, and scale up health-promoting schools to meet the Global Standards for Health Promoting Schools. Thus, the Seventy-fourth Session of the Regional Committee in 2021 will include this subject in the agenda. Recognizing the diversity of schools (public, private, monastic, faith-based education, non-formal education for migrant children, special education for children with special needs) with the particularities of pre-existing health systems in the varying socio-political landscapes of countries, cohesion via intersectoral collaboration between the health, education and other ministries will help to further equitable access to health education and strengthen health literacy in all schools.

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⁶ Thailand has expressed commitment to implement the global standards and thus proposed this agenda for the Seventy-fourth Session of the Regional Committee 2021.
Impacts of COVID-19 on education and health of children and adolescents

11. **Impact on education:** Children and adolescents have faced severe effects from school closures and other service disruptions. UNESCO has estimated that almost 1.6 billion children and adolescents of school-going age have faced school closures and other major disruptions to their learning. UNESCO states that 35 million children in the Asia-Pacific region dropped out of school during the pandemic. Children from lower-income families are increasingly less likely to return to school the longer they are away. Nearly 24 million students were at risk of not returning to school in 2020 due to the COVID-19 crisis. Further, the inequitable distribution of access to the Internet and other forms of educational technology also carries a risk that students from rural and low-income communities will fall further behind as the threat of a third wave may prompt a postponement in the reopening of schools. This may exacerbate the remote learning gap.

12. A disproportionate number of these children who may never return to school are girls and children from vulnerable groups. The financial shocks received by their parents or caregivers due to loss of income or severe reduction in income, coupled with working or learning from home have affected children and adolescents and led to stress, the likelihood of initiating the use of tobacco and other substances, cyber bullying, rights violations, gender-based violence, child marriage, among others, in many countries. Home confinement of children and adolescents is associated with uncertainty and anxiety, which is attributable to disruption in their education, physical activities and opportunities for socialization. Absence of the structured setting of the school for a long duration results in a disruption in routine, boredom and lack of innovative ideas for engaging in various academic and extracurricular activities.

13. The impacts of COVID-19 exacerbate existing inequalities for the most vulnerable children and adolescents, such as those with autism, attention deficit hyperactivity disorder (ADHD), other disabilities, in refugee camps or humanitarian settings. Tele-learning and an unstructured educational environment have impacted these children in various ways, affecting their physical and mental health as well as social well-being and safety. Children become vulnerable to exposure to violence and abuse without the partial protection they receive by going to school. Poor access to digital devices and a reliable Internet supply has disrupted children’s ability to learn and teachers to effectively teach them using a new, unfamiliar platform.

14. **Impact on nutrition:** Closure of schools during the COVID-19 pandemic deprived a number of children who relied on school meals, which could perhaps have been the only means for accessing a nutritious meal or supplementary food. As per the *State of school feeding worldwide* report released by the United Nations World Food Programme (WFP), the COVID-19 pandemic has reversed the efforts that were made worldwide over a decade to provide nutritious food to the most vulnerable children. The report highlights that when the pandemic was at its peak around April 2020, 199 countries had closed their schools by which 370 million children were suddenly deprived of their nutritious meal of the day. Presently, three million children have been affected in only 16 countries, including more than 50% of those in the SEA Region.
15. **Impact on adolescent health:** Other than the food insecurity due to COVID-19, there may be many children, especially girls, who may not be going back to school, get married at a rather early age, with its long-term implications such as lost opportunities for employment due to incomplete formal education, contributing to poverty and an increase in the incidence of teenage pregnancy. Home confinement for long periods, boredom and excessive exposure to digital media are likely to push adolescents into the use of tobacco and other substances. Simultaneously, the chances of engaging in violence and exploitation as well as child labour are also increased. The rise of these along with a family transition into poverty and financial instability during the pandemic are adversely impacting the health and well-being of children and adolescents.

16. It is crucial for school health programmes to strengthen capacity and find innovative ways to provide continuing health education and services throughout the ongoing COVID-19 pandemic. The countries in this Region need to scale up strategies and activities for school health programmes and move forward to achieve global standards, particularly with better coordination with multisectoral partners, increased investment in effective comprehensive health-promoting schools, and preparedness for more inclusive, fairer and healthier schools for all children and adolescents.

**South-East Asia landscape of school health programmes and health-promoting schools**

17. The WHO Regional Office for South-East Asia has been working with Member States for over two decades and has provided support in developing national adolescent health programmes in Member States. Implementation of school health programmes and health-promoting schools in the South-East Asia Region is varied. Countries are presently scaling up adolescent-friendly health services and have adopted a variety of strategies to address public health priorities among adolescents. Rapid assessment of school health programmes addressing adolescent health in 2019 found that some countries (such as India, Maldives and Myanmar) had a package of services for adolescents. Some countries had trained teachers and officers to implement the school health programme. Coordination between teachers and parents and the community happens only at the school level. Intersectoral coordination at the national level is found to be challenging in most countries. School health programmes in some countries focused on health education and developed information, education and communication (IEC) materials for students.

18. A recent analysis of schoolchildren in South-East Asia reported a significant burden of malnutrition. The effects of undernutrition on health and economic development consist of delayed child development, greater susceptibility to infections, poor school performance and lower earnings in adulthood. Children who suffer from undernutrition early in life are often exposed to obesogenic environments and are at a greater risk of overweight, obesity and diet-related NCDs. Poor health in childhood such as hypertension and metabolic disorders may contribute to poor school attendance and poor schooling. Children suffering from obesity have a higher likelihood of being bullied.
19. In 2021, a review of school health programmes and practices in countries of the Region found an increase in health challenges among adolescents, such as injuries due to fatal road traffic accidents, mental health conditions, depression, poisoning, substance abuse, unintended pregnancy and abortion. Member States expressed concern regarding cyber-crime and bullying on digital platforms where children spend most of their time online for schooling and other activities. However, data and research on the impact of these are not readily available.

Adolescent population and literacy rate

20. Myanmar has the largest adolescent population (26%) followed by Sri Lanka (23%), Bangladesh and Nepal (20%), Maldives (19%), Bhutan (18.7%), India (18.1%), Indonesia (16.5%), Thailand (13.3%) and Timor-Leste (10.3%). Based on recent data from the World Bank and UNESCO, the school enrolment rate in South-East Asia from 2018 to 2020 is high, and the number of children who completed primary education is encouraging. The latest data available show that completion of primary schooling is almost 100 points in all countries. The total number of pupils in primary education in these countries is 184 580 119. School is certainly the main setting that children and adolescents in South-East Asia spend most of their time during the period of growing up. However, based on recent statistics, the proportion of trained teachers in the field of primary education (% of total teachers) vary widely between countries. Bhutan and Thailand have 100% of trained teachers in primary education, while it is 97% in Nepal, 95% in Myanmar, 89% in Maldives, 83% in Sri Lanka, 73% in India and 50% in Bangladesh. Having trained teachers in schools is important for the quality of education and life-skills training for students.

21. The literacy rate of youth in all countries varies between 85 and 100 points. However, data need to be updated in many countries. Adolescents in many countries are not able to obtain formal education due to socioeconomic factors and thus join the workforce or drop out of school before completing secondary education. The literacy rate may drastically decline with increasing age. A high literacy rate does not assure a high level of health literacy because health literacy encompasses cognitive skills, recollection, information screening, accumulative experiences, responsiveness to information and choices affecting health and well-being.

Extent of the School Health Programme and Health Promoting Schools

22. A health-promoting school is a school that consistently strengthens its capacity as a safe, healthy setting for teaching, learning and working. The global standards and indicators and implementation guidance are applicable to any whole-school approach to health, even if the term “HPS” is not used (e.g. comprehensive school health, school for health, healthy learning environment, école en santé, escuela para la salud). Health-promoting schools have six characteristics: (1) foster health and learning with all available means and methods (ranging from direct teaching, peer-to-peer learning, health information and IEC materials in the school premises, to parent–teacher associations supporting enabling environments for health promotion); (2) engage health and education officials, teachers, teachers' unions, students, parents, health providers and community leaders in efforts to make the school a healthy place; (3) strive to provide a healthy environment, school health education, and school health services, along with school/community projects and outreach, health promotion programmes for staff,
nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, tobacco-free schools, social support and mental health promotion; (4) implement policies and practices that respect an individual's well-being and dignity, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements; (5) strive to improve the health of school personnel, families and community members as well as pupils; and work with community leaders to help them understand how the community contributes to, or undermines, health and education; (6) empower staff, students, families and community members to become health advocates and enhance health literacy.

23. The School Health Programme exists in all Member States of the Region for many years and schools are being utilized as a space/platform for provision of services explicitly catering to health, nutrition and physical activity. Some countries have a school health policy or adolescent health policy that focuses on service delivery and health education for students. Though the Health Promoting Schools approach has been introduced in the Region since 1997, it has not been recognized explicitly in school or health policies in many countries, except in Thailand, Maldives, and one state in India. A whole-of-school approach to promote health has not been a common practice, thus efforts to improve the health of teachers, school staff, parents and the community are not visible in most countries.

24. The structure of school health programmes is similar in almost all Member States. There is a nodal person at national, state, district and school/local levels. At the local level, there are designated persons (school staff or health-care staff) to carry out health-related activities. In all countries of the Region, many health programmes cater to school health and very few countries are taking the wholistic approach of health-promoting schools.

25. The ministries of health and education are the primary collaborators for implementing school health programmes. Maldives and Thailand have clear multisectoral coordination mechanisms with a decentralized approach for implementation at all levels. While multisectoral mechanisms exist in India, Indonesia, and Timor-Leste, their coordination can be strengthened. Some countries (such as Bangladesh, Bhutan, Myanmar, Nepal and Sri Lanka) have a centralized approach to the school health programme and have some challenges in intersectoral coordination. Inadequate financial resources and unavailability of human resources to effectively carry out school health programmes are reflected in the recent assessment.

Alignment of current implementation to the Global standards for health promoting schools

26. The Global standards for health promoting schools consist of eight standards with substantive indicators (Fig. 1) that are applied at the national, subnational and school levels. The national government is expected to have policies and resources to support health-promoting schools and make it possible for every school to be a health-promoting school. National policies will also guide school policies and resources as well as strengthen curriculums, services and create an enabling environment for all who teach, learn and work in schools. Policy support is important for multisectoral coordination, governance and partnerships among schools and communities, as well as other sectors. At the subnational level, school policies and resources, governance, leadership and community partnerships have major sets of standards. At the school level, there are standards for the school curriculum, health services, physical and social–emotional environment, which are crucial.
Figure 1: Relations among global standards for health-promoting schools

Source: Global standards for health promoting schools

27. Based on a recent assessment in 2021, with country consultations and responses received from seven countries (Bangladesh, Bhutan, Maldives, Myanmar, Indonesia, Sri Lanka and Thailand) in South-East Asia, the following findings reflect how current practices are aligned with the eight global standards. Scoring is done according to whether practices completely, partially or inadequately meet the standards, in consultation with the health and education sectors of the countries that provided a response. Multisectoral coordination is mainly between the ministries of education and health. It varies in different countries of the Region and is the most critical determinant of the success of school health programmes. Presently, the decentralized approach to school health programmes with clear multisectoral coordination mechanisms has been established in Maldives and Thailand. In India, Indonesia, and Timor-Leste the mechanisms are there but there is poor intersectoral linkage in practice. In Bangladesh, Bhutan, Myanmar, Nepal, and Sri Lanka, it is a big challenge to implement the centralized approach to school health programmes because of poor intersectoral coordination mechanisms.

28. The findings of this assessment show that implementation of school health programmes in South-East Asian countries is not holistic or completely aligned with the health-promoting schools’ approach. Thailand and Maldives are the two countries that have the most comprehensive health-promoting school practices and could be early adopters to meet these new global standards for health-promoting schools. Case studies from the global report also demonstrate that Bhutan and Indonesia have commitments and supportive factors to implement health-promoting schools. Implementation of health-promoting schools is feasible in South-East Asia.
Emerging factors for implementation of the global standards for health promoting schools

29. **Urgent need for a better database of child and adolescent health in all types of schools.** There is inadequate information on child health during this critical period of development. Global school-based health surveys (GSHS)\(^2\) assess the behavioural risk factors and protective factors in 10 key areas (alcohol use, dietary behaviours, drug use, hygiene, mental health, physical activity, protective factors, sexual behaviours, tobacco use, violence and unintentional injury) among young people aged 13–17 years. The surveys were carried out periodically, subject to readiness in countries to conduct the surveys. Some information is available from schools in many countries but is underutilized. There is no systematic record of health conditions in various types of schools in countries.

30. **Children in the primary school age group, role models, and continuum of care:** Children in the primary school age group are dependent on others, such as parents, teachers and caretakers, and the environment in which they live, learn and play. They need role models both in school and at home. Teachers and parents need to adopt healthy behaviours to be role models and have functional health literacy. They should also try to create an enabling environment for children to reach good health and educational outcomes. Homes and schools have to be aligned to provide a continuum of quality care to children. Efforts made in schools may not be continued if parents, teachers and the community do not harmonize their efforts to promote optimum health behaviours for children in their care.

31. **Integrated healthy workplace in school settings:** As part of health-promoting school standards, schools should also be healthy workplaces for teachers and staff. A healthy working environment promotes physical, mental and social well-being and benefits the health outcomes of teachers and staff, and is thus likely to generate positive effects on children’s health. Promotion of physical activity, mental health and psychosocial support is important for all staff. Health literacy among policy-makers and the school management will make healthier choices possible. Health-promoting schools can generate a positive ripple effect on health outcomes and productivity of every school staff member and teacher.

32. **Commitment to multisectoral action:** Commitment to multisectoral action needs to be explicit, from policy, programmes, implementation, and monitoring and evaluation at all levels. Desirable actions should be **jointly conducted for success**, and integrate efforts from different partners at one time, rather than dividing the roles and responsibilities of each. Multisectoral actions for whole-of-school, whole-of-society, and whole-of-government approaches need to be deliberate, and agreed upon with different stakeholders (parents, teachers, students, communities) and agencies involved in delivering different components of health, education and enabling factors.

33. **Recognition of educational diversity and diverse health needs of children in all types of schools:** All countries have an increasing demand for education. Various types of education exist in all countries, ranging from education for special needs children, children with disabilities, those in humanitarian settings, temporary learning facilities, to home-schooling, religious schools, private and public schools. Every type of school will need to have elements of health integrated into education as part of their basic education. Equity is an important element of health-promoting schools; thus no child, in any type of school, should be deprived of health education, health literacy, health services, and a supportive, safe and inclusive environment while they are in school or educational facilities.
34. **Public health and emergency preparedness in all schools**: With lessons learnt from COVID-19, every learning facility needs to adapt to new ways of learning and take health measures in everyday operations, at the least in sanitization, personal hygiene, respiratory etiquette and physical distancing. Mental health and psychosocial support during the COVID-19 pandemic through online education must be supported. Schools should be equipped with public health preparedness and health-promoting schools should be an integral part of a recovery plan. Health measures would be an important part of the new normal.

**Conclusion and call for action**

35. As Thailand proposed in the High-Level Preparatory (HLP) Meeting (virtual) for the Seventy-fourth Session of the WHO Regional Committee for South-East Asia held at the Regional Office, 19–21 July 2021, Member States would like to build upon the new global initiative on health-promoting schools and the urgent need to acknowledge the importance of school health in a comprehensive manner with concrete actions. Member States thus call for commitment and strong collaboration between the health and education sectors at the policy level, resulting in school and community engagement at the school level.

36. This background paper serves as evidence of the need to revitalize health-promoting schools in the South-East Asia Region and support the resolution to take concrete actions. The Resolution on “Revitalizing School Health Programmes and Health Promoting Schools in South-East Asia Region” will cover two essential components:

A. Develop a **regional roadmap** to scale up school health programmes and health-promoting school practices to meet the Global Standards for Health Promoting Schools and strengthen collaboration between the health and education sectors. The roadmap will consist of three main components:

- Update the database on national and subnational policies for school health and the situation related to health-promoting schools in the Region.
- Identify current critical public health issues, and policy and implementation gaps across the Region.
- Guide priority areas to accelerate actions to meet the global standards.

B. Recommend all possible **mitigation measures** (such as hygiene, sanitization, respiratory etiquette and physical distancing during the COVID-19 pandemic and other measures in different types of public health emergencies and outbreaks in the future) to be implemented in all schools. Schools and educational institutions should be encouraged and supported to conduct active roles in health education, preparedness and engagement with students, parents, teachers and communities, communicating the risks and effective measures during the current pandemic and future public health emergencies. In accordance with the Global Standards for Health Promoting Schools, a whole-of-school approach to promoting health and well-being for all students, teachers, school staff, parents and the community should be invested in through multisectoral partnerships.
References


