

Short Communication

Health promoting school: a comprehensive situation analysis

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ABSTRACT

Background: Situation analysis regarding health in an organisation or community is the systematic process of collecting, analysing, and interpreting data about health issues within a specific population or community. Given this context, the present study conducted a practical comprehensive school-related health situation analysis by utilising nine (9) distinct components (physical components to school health policies) regarding the HPS of a selected government higher secondary high school in Sundarban district, West Bengal, India.

Methods: A school-based cross-sectional study was conducted from October 2024 to November 2024. A close-ended predesigned, structured questionnaire was used, and quantitative research methods were applied.

Results: The analysis of 1,417 responses about the nine health promotion components reveals crucial insights into school health support. Notably, 424 (30%) respondents definitively "no" stated the components were absent, while 157 (11%) found them "not adequate." Additionally, 447 (31.5%) provided "no remark," indicating uncertainty or disengagement. Conversely, 389 (27.5%) affirmed the components were satisfactory with a "yes".

Conclusions: This mixed feedback highlights the need for targeted interventions to improve the perceived adequacy of school health services and support systems. It is clear that while some aspects may be functioning well, there is a significant opportunity for enhancement across all nine components.

Keywords: Health promotion, Health policy, Situation analysis, Comprehensive, India, School

INTRODUCTION

Situation analysis regarding health in an organisation or community is the systematic process of collecting, analysing, and interpreting data about health issues within a specific population or community. This analysis helps to identify health needs, challenges, and resources available to address those needs. Key components of a health situation analysis include data collection, which involves gathering both quantitative and qualitative data on health indicators such as disease prevalence, health behaviours, access to healthcare, and social determinants of health. Stakeholder engagement is also crucial, involving key stakeholders like community members, health professionals, and policymakers to gain insights and perspectives on health issues.¹

Additionally, the situation analysis assesses the strengths and weaknesses of the community's existing health programs, services, and resources. It also identifies opportunities and threats that could impact health, such as policies, funding, and community support. Finally, based on the analysis, actionable recommendations are provided for improving health outcomes and addressing identified challenges. Overall, situation analysis is essential for informing health policies, programs, and interventions to promote better health outcomes in a specific population or universal community.¹

A health-promoting school is a setting where all school community members come together to create a supportive and enriching environment that prioritizes students' health and well-being. This involves not only the structured

health education curriculum but also informal learning experiences, fostering a safe and healthy atmosphere, providing access to essential health services, and encouraging the participation of families and the larger community in initiatives that promote health.^{2,3}

In India, the Rashtriya Bal Swasthya Karyakram (RBSK) monitors health from birth to 18 years, identifying issues early. The Rashtriya Kishor Swasthya Karyakram (RKSK) addresses the health needs of teens aged 10 to 19, focusing on nutrition and mental health. The Ayushman Bharat School Health Program (SHP-AB) enhances children's health. These programs collectively help children and teens maintain health and succeed in school.⁴⁻⁶

Multiple studies have highlighted the need for policies, support, comprehensive strategies and urgent intervention within the school community.^{7,11,12} Several studies examined school nutrition programs, highlighting their importance in encouraging healthy eating habits among adolescents. Obstacles include restricted access to nutritious food, insufficient food safety measures, and a lack of awareness regarding healthy eating among students and staff. Lack of understanding regarding eye health among managers, negatively impacting student's quality of eye care. The main obstacles are limited resources, insufficient training, and restricted service access.⁸⁻¹⁰ It is observed that the comprehensive present situation of school-related health based on nine (9) different components is not highlighted, that help to make policies, support, and strategies in future within the school community. Comprehensive and effective situation analysis regarding school-related health helps a school to become a "health-promoting school" and decision-making for the future. It will reduce morbidity and economic burden in the long run.

Given this context, the present study conducted a practical comprehensive school-related health situation analysis of a selected government higher secondary high school using nine distinct components of HPS in Sundarban district, West Bengal, India.

Objectives

Objectives of the study were to assess the present school-related health situation of a selected government higher secondary high school using nine distinct components of HPS; and to explore opinions among students, the headmaster, the assistant headmaster, and the president of the school managing committee concerning the current status of school-related health.

METHODS

A cross-sectional study was conducted from October 2024 to November 2024, in a selected government higher secondary high school in Sundarban district West Bengal. Due to time constraints, a large number of questionnaires and a lack of mass written consent from the school's

population, the researcher selected two students, one male and one female, from each class between VIII and XII, as well as the school's headmaster, assistant headmaster, and president of the managing committee. Who gave written consent by their thoughts and beliefs and who are interested in this research. However, the study comprised a total of 13 individual participants.

Inclusion criteria

Students, headmaster, assistant headmaster, and president of the managing committee who had attained during data collection and were willing to take part in the study.

Exclusion criteria

People who were seriously ill, absent during the data collection and not interested in participating in the study.

Necessary permissions from authorities were also obtained before conducting the study. Informed written consent was taken from 13 individual participants. Consent forms and information sheets in the local language, along with pre-designed and structured questionnaires, were employed to explore study participants' opinions regarding nine (9) different components of "health promoting school". The questionnaire was initially developed in English and subsequently translated into Bengali by a linguistic expert to ensure semantic equivalence. To verify the accuracy of the translation, two independent researchers, who were not privy to the original English version, retranslated it back into English.

The closed-ended questionnaire utilized a multiple-choice format. Participants indicated their choices using a tick symbol and they can choose only one option code. Codes were employed as follows: N for no, Y for yes, NA for not adequate, and NR for no remark (total 4 codes). Similarly, to minimize hesitation and enhance data analysis for participants and researchers, the serial numbers of questions were coded using distinct codes corresponding to their respective nine (9) different types of component names.

The "physical components" (PC) category comprised 40 questions, resulting in 520 responses (40×13). The "physical activity" (PA) category contained 12 questions, yielding 156 responses (12×13). The "psychological components" (PSC) category consisted of 10 questions, generating 130 responses (10×13). The "nutritional components" (NC) category included 6 questions, producing 78 responses (6×13). The "basic health services" (BHS) category encompassed 12 questions, resulting in 156 responses (12×13). The "health education" (HE) category contained 6 questions, yielding 78 responses (6×13). The "teachers and other staff" (TOS) category comprised 4 questions, generating 52 responses (4×13). The "community relationship" (CR) category consisted of 5 questions, producing 65 responses (5×13).

The "school health policies" (SHP) category included 14 questions, resulting in 182 responses (14×13).

The questionnaire comprised 109 distinct questions, 109 unique question codes, and 1417 responses (109×13 individual participants). The printed questionnaire and writing instrument were distributed to 13 participants individually, with a two-hour time allocation. Participants completed their responses in separate rooms under the direct supervision of the researcher. Initial data entry was performed in Excel, and subsequent analysis was performed using Jamovi 2.6.

RESULTS

Of the 1,417 responses, "no (N)" constituted 424 (30%), "not adequate (NA)" comprised 157 (11%), "no remark (NR)" accounted for 447 (31.5%), and "yes (Y)" represented 389 (27.5%).

"PC", out of 520 responses, "N" constituted 126 (24.3%), "NA" comprised 84 (16.1%), "NR" accounted for 141 (27.1%), and "Y" represented 169 (32.5%).

"PA" out of 156 responses, "N" constituted 48 (30.7%), "NA" comprised 12 (7.7%), "NR" accounted for 60 (38.5%), and "Y" represented 36 (23.1%).

"PC" out of 130 responses, "N" constituted 37 (28.5%), "NA" comprised 4 (3%), and "Y" represented 89 (68.5%).

"Nutritional components" out of 78 responses, "N" constituted 10 (12.9%), "NA" comprised 13 (16.7%), "NR" accounted for 33 (42.4%), and "Y" represented 22 (28%).

"Basic health services" out of 156 responses, "N" constituted 76 (48.5%), "NA" comprised 13 (8.5%), "NR" accounted for 45 (28%), and "Y" represented 22 (15%).

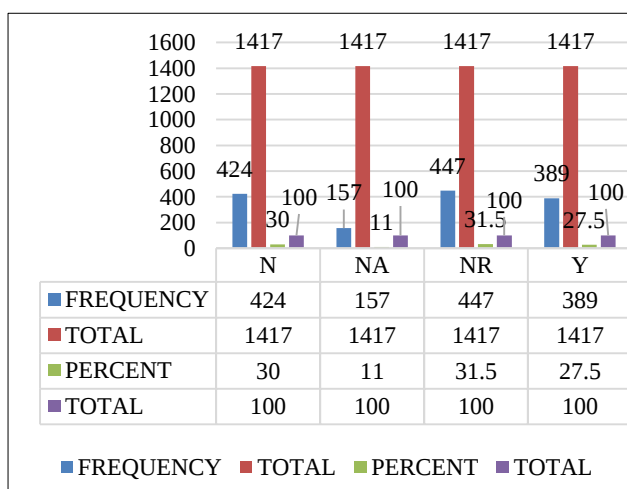


Figure 1: Frequency distribution of responses regarding 9 components, from question no PC1 to SHP14 (109 different types question).

Table 1: Frequency distribution of responses regarding nine (9) individual components of HPS.

Response	Frequency	Percent
PC to NC		
Physical component		
N	126	24.3
NA	84	16.1
NR	141	27.1
Y	169	32.5
Physical activity		
N	48	30.7
NA	12	7.7
NR	60	38.5
Y	36	23.1
Psychosocial component		
N	37	28.5
NA	4	3
Y	89	68.5
Nutritional component		
N	10	12.9
NA	13	16.7
NR	33	42.4
Y	22	28
BHS to SHP		
Basic health services		
N	76	48.5
NA	13	8.5
NR	45	28
Y	22	15
Health education		
N	43	55
NA	14	18
NR	17	22
Y	4	5
Teachers and other staff		
NR		52
Community relationship		
N		44
NA		6
NR		10
Y		5
School health policies		
N		40
NA		11
NR		89
Y		42

Physical component: PC, physical activity: PA, psychosocial component: PSC, nutritional component: NC, basic health services: BHS, health education: HE, teachers and other staff: TOS, community relationship: CR, school health policies/legislation: SHP, no: N, no remark: NR, not adequate: NA, yes: Y, health promoting school: HPS

"Health education" out of 78 responses, "N" constituted 43 (55%), "NA" comprised 14 (18%), "NR" accounted for 17 (22%), and "Y" represented 4 (5%).

“Teachers and other staff” out of 52 responses, “NR” accounted for 52 (100%).

“Community relationship” out of 65 responses, “N” constituted 44 (68%), “NA” comprised 6 (9.5%), “NR” accounted for 10 (14.5%), and “Y” represented 5 (8%).

“School health policies” out of 182 responses, “N” constituted 40 (22%), “NA” comprised 11(6%), “NR” accounted for 89 (49%), and “Y” represented 42 (23%).

DISCUSSION

The background context of the situational analysis emphasises the importance of systematically evaluating health-related issues within a government higher secondary high school. The nine components used in this analysis—from physical components to school health policies—provide a comprehensive framework for understanding the multifaceted nature of health promotion in schools this indicates that a portion of the school population recognizes and appreciates the efforts made to promote health within the school environment.

The data reveals that a significant portion of respondents, 30% expressed a clear “no” regarding the adequacy of the existing health components. This finding is concerning as it indicates a widespread perception of inadequacy in the health support systems available within the school. Furthermore, the 11% who deemed the components as “not adequate” further emphasizes the need for improvement. The high percentage of respondents 31.5% who chose “no remark” suggests a lack of engagement or understanding of the health components, which could point to insufficient communication or awareness efforts within the school community. On a more positive note, 27.5% of respondents affirmed that the health components were satisfactory with a “yes”.

The findings suggest that while some components may function adequately, others require significant attention and enhancement. However, the relatively low percentage of satisfaction highlights the need for further investigation into the specific areas where improvements are necessary. The analysis underscores the necessity for targeted interventions to address the identified gaps in health promotion within the school. Strategies should focus on improving communication about health resources, increasing engagement among students and staff, and ensuring that all components are adequately supported and implemented. By doing so, the school can foster a more robust health-promoting environment that effectively meets the needs of its students and staff.

Goodfellow et al found that low preconception health awareness hinders interventions and raises unplanned pregnancy rates. Challenges include knowledge gaps, limited capacity, and care adherence. A comprehensive strategy is needed to enhance school curricula on parenthood, increase awareness, and provide equal

preconception services. Improving care before and between pregnancies is vital for better outcomes for women and infants.⁷ Rector et al examined school nutrition programs, highlighting their importance in encouraging healthy eating habits among adolescents. They point out challenges like limited funding, lack of trained personnel, and minimal community engagement. The authors suggest improving resource allocation, providing staff training, and increasing community involvement to enhance these initiatives and promote youth well-being.⁸

Rachmadewi et al recognised obstacles like restricted access to nutritious food, insufficient food safety measures, and a lack of awareness regarding healthy eating among students and staff. The study calls for enhanced policies and initiatives to elevate food quality in school canteens, emphasising their crucial role in shaping children's dietary choices and providing safe, nutritious options.⁹ Prakash et al found a lack of awareness regarding eye health among managers, negatively impacting students' quality of eye care. The main obstacles are limited resources, insufficient training, and restricted service access. They emphasize the importance of enhanced training and better resource distribution to boost eye health outcomes in special schools and assist vulnerable groups in India.¹⁰ Patel and Bansod identified serious self-rated health (SRH) issues among urban adolescent girls, particularly those from scheduled caste (SC) and scheduled tribe (ST) households who face more challenges. Girls with brothers report worse SRH than those without, highlighting the need for policies that support maternal health for girl's SRH.¹¹ Vastrad et al highlighted undernutrition as a major public health concern, emphasizing the need for urgent interventions. They suggest that tackling undernutrition is crucial for improving children's health and welfare, which may impact their long-term development and education.¹²

Limitations

This study has several limitations that must be acknowledged. Firstly, the research was conducted in a single higher secondary school in the Sundarban district, which may limit the generalizability of the findings to other schools or regions. The unique socio-economic and cultural context of the Sundarban area may influence the health promotion components differently compared to different settings.

Secondly, the reliance on a close-ended structured questionnaire may restrict the depth of responses. While it allows for quantitative analysis, it may not adequately capture the nuances of participants' perspectives on health promotion. Open-ended questions could have provided richer qualitative data, enhancing the understanding of the respondents' views.

Lastly, the study's cross-sectional design prevents establishing causal relationships between the identified components of health promotion and the respondent's

opinions. Longitudinal studies would be beneficial to explore the changes over time and the impact of specific interventions on school health policies.

CONCLUSION

This analysis will underscore the critical importance of collaboration among diverse stakeholders, including educators, parents, and community organizations, in establishing a comprehensive support system. Moving forward, it will be imperative to address these inequities and enhance communication strategies to ensure that all students are adequately equipped to maximize the benefits of health promotion. Collaboration among these groups will create a holistic support system that can effectively meet the diverse needs of students. Each stakeholder will contribute unique perspectives and resources that will enhance the overall effectiveness of health promotion initiatives.

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