

Health promotion and students' well-being in secondary schools in Catalonia

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Abstract

Objective: The aim of this study was to analyse the views of different members of the school community regarding the health and well-being of young people and health promotion in schools.

Design: Case study design was used, in which the Personal Wellbeing Index–School Children's Questionnaire was administered to young people, and focus groups were held with other members of the school community (students, teachers, families, tutors and stakeholders).

Setting: Five secondary schools in Catalonia (Spain).

Method: Sequential triangulation between methods. Quantitative methods evaluated the students' perception of health and well-being, while qualitative methods described school community perceptions of health promotion in school.

Results: The results revealed a generally good perception of health among young people. Reported perceptions of health were lower among students in the later years of secondary education. Findings suggest that health promotion actions do not always translate into healthy behaviours among young people. Lack of resources and school overcrowding are key contextual factors influencing the promotion of health.

Conclusion: Findings advance knowledge related to health education during the secondary years of schooling. In addition, they provide professionals with relevant data for developing and implementing health and well-being actions to include as part of a holistic curriculum.

Keywords

Health promotion, secondary schools, Spain, well-being, young people

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Health-promoting schools

In 2016 in Shanghai, government leaders and United Nations organisations, mayors and health experts signed two historic agreements to promote public health and eradicate poverty: the *Shanghai Consensus on Healthy Cities* statement and the *Shanghai Declaration on Health Promotion*. The event marked the 30th anniversary of the equally historic *Ottawa Charter for Health Promotion*, which had noted the need to foster political commitment, action and investments to address health and equity.

The said Charter also highlighted the importance of environments or settings for the promotion of health and provided the basis for the World Health Organization (WHO), in collaboration with the European Commission and the Council of Europe, to lead an initiative to promote health in schools during the 1990s (Nutbeam, 2018). As far back as 1948, WHO understood health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Over time, this approach shifted the focus away from disease to a new concern for health promotion (WHO, 1986), with the new construct empowering individuals and fostering the ability to adapt and self-manage one's own state of health (Kok et al., 2016).

In 1995, WHO established a set of guidelines for institutions wishing to identify themselves as health-promoting schools (HPSs) on the understanding that by providing health education they could address wider public health problems (Santelli et al., 1998). Research has shown that healthier students are better learners (Murray et al., 2007; Suhrcke and de Paz, 2011) and that promoting health during the adolescent years is key to preventing diseases in adulthood. Secondary school is an important setting for health promotion, offering a wide-ranging and efficient means of reaching the youth population. Furthermore, a secondary school is a relevant context for addressing and managing health-related issues within a broader educational context (Langford et al., 2015).

The European Network of Health Promoting Schools (ENHPS) was created to promote health in the school setting across Europe (Whitman, 2005). It currently involves more than 50 countries and around 40,000 schools, and now goes by the name of *Schools for Health in Europe (SHE)*. According to the SHE School Manual, an HPS is one that supports a whole-school approach. An HPS addresses health and well-being in a systematic and integrated way in line with an explicit plan and procedure. It is oriented towards action and participation by the whole community, including students, teaching and non-teaching staff, and parents, and works on competences related to developing knowledge and skills, seeking the commitment of all members of the school community (young people, families, tutors, and health managers or stakeholders involved in health education) to promote health and well-being (Safarjan et al., 2013: 9).

The aim of this new paradigm has been to overcome the limited success of more traditional health education by promoting a holistic approach that recognises the multidimensional aspects of health promotion in secondary schools (Cala et al., 2016; Langford et al., 2015). Over the last 20 years, different strategies and programmes have been implemented across Europe under names as diverse as *Health Promoting Schools*, *Comprehensive School Health*, *Schools for Children* and the initiative *Focusing Resources on Effective School Health (FRESH)*. The core elements in each of these strategies are that the school adopts a comprehensive approach to health promotion in recognition of the fact that everyone within the school community has a role to play in promoting health (Clift and Jensen, 2005; Leger, 2005; Leger et al., 2010; Young, 2005). The HPS approach seeks to integrate concern for positive health in three basic domains: in the curriculum, in the school itself and its wider environment, and through families and communities (Leahy and Simovska, 2017). Through its work, an HPS seeks to help its members make health decisions, improve awareness and empower health-enhancing behaviours, tackle health inequalities among adolescents and

sustain positive health beyond school (Durlak et al., 2015; European Union, 2015; Organisation for Economic Co-operation and Development [OECD], 2015). Adopting a comprehensive and holistic approach to health provides young people with opportunities to get involved and participate in knowledge generation regarding health along the teaching–learning continuum (Díaz-Vicario and Gairín Sallán, 2017; Huber et al., 2011).

To implement an effective and sustainable health promotion programme in secondary school, it is important to recognise four different phases of work: pre-implementation, anchoring and preparation, delivery and sustainability. The process at all stages should be a collaborative one, involving parents, teachers, headteachers, school administrators and other stakeholders (Chilton et al., 2015). Insofar as it meets these criteria, the HPS has proven effective in improving student health as part of the learning process. That said, however, a meta-analysis conducted by Langford et al. (2015) in a recent Cochrane review identified a number of methodological limitations of the process, including an over-reliance on self-reported data, difficulties in securing parental involvement, lack of long-term follow-up, high attrition rates, and difficulties bringing about significant changes in health behaviour.

Several studies (Jessiman et al., 2019; Mohamed, 2015) have aimed to describe and evaluate the school health models and projects developed by HPS programmes. In their study, Sulz et al. (2016) carried out an in-depth analysis of secondary teachers' and students' experiences of, and motivations for, participating in these models. Analysis of the data from their study revealed five themes associated with participants' experiences and motivational processes: (a) lack of time for planning and preparation; (b) the importance of resources, workshops and collaboration with other teachers and health professionals; (c) teacher control impacting student engagement; (d) teachers' work inhibiting the implementation of HPS action plans; and (e) choice-based design impacting participants' experiences. Together, and in the words of Basch (2011), 'what has been lacking is a set of strategies for motivating and enabling school leaders, teachers, and educational stakeholders to put high quality school health models into practice in their schools' (p. 652).

A study conducted by McIsaac et al. (2015) confirmed the importance of integrating the work done by HPSs with broader educational values to enable the development of partnerships between health and education sectors. In support of such a goal, a key priority for the future development of HPSs, according to Cala et al. (2016) and Pearson et al. (2015), is to determine which health promotion programmes are more efficient and more successfully implemented in different secondary schools.

Salvador's (2008) report on health promotion and education in schools in Spain identified a lack of training and resources as obstacles to achieving the promotion of health in Spanish schools. In addition, the following difficulties were also detected: health promotion and education not being seen as a priority in educational policy, lack of funding resulting in the need to incorporate volunteer staff to support health promotion, the perception that health issues only pertain to health workers, coordination difficulties between education and health departments, the large number of training courses on offer, and limited family involvement. The conclusions to a study by Vega et al. (2014) based on an investigation carried out on 24 secondary schools in the Basque Country revealed that many of these obstacles still persist several years later.

Given these difficulties, there is a clear need to initiate a new generation of research that focuses on the relationship between education and students' health between the ages of 12 and 18 years.

Aims and methodology

This article details findings from a recent study carried out in Catalonia (Spain), which had the following aims:

Table 1. Distribution and average age of the 632 participating students by school year.

School year	N	%	Average age (years)	SD
Year 7	139	21.99	12.38	0.53
Year 8	138	21.84	13.49	0.61
Year 9	118	18.67	14.24	0.57
Year 10	83	13.13	15.36	0.74
1st year Baccaalaureate	113	17.88	16.38	0.50
2nd year Baccaalaureate	41	6.49	17.36	0.53
Total	632	100		

SD: standard deviation.

1. To determine secondary school students' perception of health and well-being;
2. To describe the school community's perceptions of health promotion in schools.

A mixed methodology was used to carry out the study. In principle, the integration of quantitative and qualitative methods helps minimise the limitations of qualitative and quantitative approaches alone. It also provides a useful means of explaining quantitative results by reference to relevant qualitative analysis (Creswell, 2014).

Fieldwork was carried out in case study schools in Catalonia. The schools shared similar socio-economic and demographic characteristics. In each of the two case study schools, the Personal Wellbeing Index–School Children's (PWI-SC) Questionnaire was administered to young people, and focus groups were held with members of the educational community. Focus groups were also held in a further three schools (five in total). The findings from both methods were triangulated with researchers and participants. The study was approved by the University of Girona's Ethics and Research Committee.

Quantitative methods

Satisfaction with health and well-being

The aim of the quantitative element of the study was to determine perceptions of health and well-being among students in local secondary schools.

The target population of the study comprised 1,365 students attending two secondary schools (one located in a rural and the other in an urban area). The students were distributed across six academic years and aged between 12 and 18 years. To ensure representativeness, a stratified systematic sample of 632 students was drawn from a total of 1,365 students using school years as strata. Table 1 shows how the 632 participants were distributed.

Quantitative data were collected by means of the PWI-SC, a valid and reliable instrument developed to determine perceptions regarding children and adolescents' health and well-being in an educational context. Although the PWI-SC was originally designed for use with adults, it has been tested with 12-year-olds and older children in some countries and exhibits good psychometric properties (Casas et al., 2013).

The PWI-SC comprises eight questions focusing on satisfaction with eight aspects of subjective well-being (happy with life as a whole, standard of living, personal health, achievement in life, personal relationships, personal safety, feeling part of the community, future security). Responses are provided on a Likert-type scale from 0 to 10, with 0 corresponding to 'totally unsatisfied' and 10 to 'completely satisfied'. Results are recorded out of 10 and expressed as a percentage.

Table 2. Focus group composition.

	Students	Teachers	Family	Youth workers and health managers	Total
Public school A	21	6	0		27
Public school B	18	5	3		26
Public school C	5	6	4		15
Public school D	20	7	4		31
Public school E	25	6	4		35
Youth workers and health managers				5	5
Total	89	30	15	5	139

The Kruskal–Wallis test was used to compare the distribution of perceptions of health and well-being variables across different school years. As there were six different school years in total, this meant studying the differences between 15 pairs. All statistical tests were two-sided, and statistical significance was set at $p < .05$.

Qualitative methods

Focus groups

For the qualitative elements of the study, focus groups were conducted using the principles of grounded theory. These groups aimed to identify students', families' and teachers' concepts of health and well-being, and their determining factors in secondary schools. The sample comprised 139 individuals drawn from five case study schools. Three focus groups took place in each school, involving students, families and teachers. In addition, one focus group was conducted with youth workers and health managers from the town councils where the schools were located. The distribution of participants across the different focus groups is shown in Table 2.

Focus groups were informed by a semi-structured set of questions and lasted around 45 minutes. Participants' views were audio-recorded with prior informed consent and were subsequently transcribed for analysis. Constant comparative method was used to analyse the information from focus groups and led to the identification of five categories and 11 subcategories of response.

Findings

Students' perceptions regarding health and well-being

The sample comprised 314 (48.68%) girls and 311 (49.21%) boys. Seven (1.11%) students did not state their gender in the questionnaire. Overall for the sample, the average well-being score was 80.86 points, with a standard deviation of 12.47 points. The lowest value was 4.29 points and the highest 100 points.

Students in year 7 had the highest average score regarding perceptions of health and well-being, with a value of 85.8 points. Students in the first year of Baccalaureate had the lowest average score, with a value of 75.03, although this was almost the same as students in the second year of Baccalaureate (75.12) (see Table 3).

To analyse health and well-being perceptions by school year, the nonparametric Mann–Whitney–Wilcoxon test was used. A statistically significant difference was found between all school years, except for consecutive ones: Years 8 and 9 ($p = .82623$), years 9 and 10 ($p = .07609$) and first and second year Baccalaureate ($p = .82190$).

Table 3. Perceptions of health and well-being by school year.

School year	X	SD	Min.	Q25	Mean	Q75	Max.	N
Year 7	85.76	11.11	48.57	80.71	88.57	94.29	100	139
Year 8	82.01	12.77	4.29	78.57	84.29	89.64	100	138
Year 9	82.11	12.40	20	77.50	82.86	90	100	118
Year 10	79.78	11.65	40	72.86	80	88.57	100	83
1st year Baccaulaureate	75.03	12.29	18.57	70	75.71	81.43	100	113
2nd year Baccaulaureate	75.12	9.74	52.86	70	77.14	81.43	98.57	41

SD: standard deviation; X: average.

Table 4. Responses to the Personal Wellbeing Index–School Children’s Questionnaire.

Question number and description	Mode	Students (total)	Percentage	χ^2	p value
1. Happy with life as a whole	80	183 (632)	28.95	110.65	.0005
2. Standard of living	80	189 (632)	29.90	87.39	.0005
3. Personal health	100	204 (632)	32.27	92.57	.0005
4. Achievement in life	80	167 (632)	26.42	64.02	.028
5. Personal relationships	100	178 (632)	28.16	88.32	.002
6. Personal safety	90	138 (632)	21.83	84.22	.001
7. Feeling part of the community	100	268 (632)	42.40	89.39	.003
8. Future security	70	136 (632)	21.51	139.4	.0005

The results show that in terms of perceptions of health, students expressed greatest satisfaction with the groups of people they belong to, awarding it the maximum value of 100 (42.40% of the sample); their personal health (32.27%); and relationships with other people (28.16%). The lowest satisfaction expressed, with a value of 70, related to security about the future (21.51% of the sample) (Table 4).

With regard to gender differences in perceptions of health and well-being, girls’ averages (79.77, SD=12.86) were lower than boys’ (82.19, SD=11.56). This result was statistically significant ($p=.01889$).

Promoting health and well-being in the educational community – focus groups

A multidimensional concept of health was identified in the views of the four focus groups which included physical, psychosocial and emotional elements. Both teachers’ and family members’ groups highlighted the importance of a balance between these three elements and linked health to healthy habits. The views expressed by youth workers and health managers were different in that they worked from a more holistic concept of health in which emotional health came first.

Young people’s perceptions of health. All groups acknowledged that major inequalities exist regarding young people’s health, which in some specific cases can reach worrying extremes. The teachers added that the situation is becoming increasingly unbalanced and that what were previously seen as exceptions will soon become the norm. Health deficits or problems specifically mentioned included addictions (smoking, alcohol, the mobile phone and its applications), poor eating habits, lack of rest, and anxiety and stress.

Moreover, the focus groups confirmed that young people's state of health is heavily affected by stress, fatigue and the level of demands (and self-demands) that many are subjected to:

I don't think anxiety is good for health. There are people who handle it better, there are people who cannot handle it. It increases with each passing year . . . [. . .] In other words, it's a constant weight, pressure, pressure, pressure all day long. (B-Students, 230–235)

In addition to health deficits or problems, teachers also mentioned lack of self-esteem and difficulty in taking on challenges, peer pressure, and behavioural and emotional problems. Furthermore, the family group highlighted a lack of authentic relationships between students at school and in the community and the isolation that some young people experience. The youth workers and health managers' group also commented on the growing problem of a sedentary lifestyle aggravated by the short but intensive school day currently implemented in local secondary schools (commencing at 8 a.m. and finishing at 3 p.m.) and its impact on nutrition, social relationships and physical activity.

Health issues and responses. There was agreement among students about the pressure of parental expectations and the fact that on occasions this can be totally counterproductive. Teachers stated that the family is very important but that some families are totally overwhelmed by young people's health problems. For example, at times it is clear that education received at home and at school does not coincide, and when this happens they feel that the education given by the family has greater weight. Youth workers and health managers stated that the relationship between the family (origin, socioeconomic level, religion, affective relationships, etc.) and the school is fundamental. One outstanding need is to increase the level of education in families because ' . . . it influences the health of their children and, in the long run, their life expectancy' (Youth workers and health managers, 975–976).

Youth workers and health managers stressed that for young people there needs to be a bond of trust that allows professionals to reach them and start the educational work. However, 'the feeling is that we're arriving [too] late. The situation is being detected at very early ages' (A-Teachers, 460). They also reported that some young people cannot be treated, although they can be accompanied in their process: 'As teachers, we go as far as we can, but [we] can't do more beyond that point' (C-Teachers, 256–257).

To improve health in schools, students stressed the need to better manage the pressures of examinations and improve the furniture in classrooms, especially chairs, and access to and conditions in toilets.

Teachers, on the contrary, wanted closer contact with families and additional resources and more specialised personnel: 'What happens is that sometimes it is cheaper to say "Let them do a 30-hour training course" than sending in a professional' (E2, 560–562). Teachers added that for unknown and complex health problems, the student should be referred to specialists and expert professionals from e-support and special education units so as to ensure the provision of targeted and effective attention:

. . . What we need more than anything else is more staff to be able to provide more attention. [. . .] More child psychologists and social workers who can attend to these kids, who have some time to be there for them. (B2, 593–598)

Students, families and teachers all emphasised the need to increase the number of teacher-led relaxation exercises offered to students between classes. They also noted the need to manage the stress and competitiveness caused by within-school dynamics: 'not to educate based on anxiety, not to educate in that way of being the best, the best, the best' (B-Families, 909–910). All groups agreed on the need to improve cafeteria services and vending machines to promote a healthier diet.

Health promotion

With regard to student education on concepts of health, the teachers, families, youth workers and health managers all stated that although activities related to health were carried out in secondary schools, they are often not effective. Teachers emphasised that students often have the necessary knowledge on health matters, but do not integrate this into their lives: ‘they have the information, of all kinds, healthy habits, meditation, everything, . . .’ (B-Teachers, 458). Family members too noticed that theoretical knowledge does not seem to inform the behaviour of young people in their daily lives. As the youth workers and health managers pointed out,

They know what they have to do in order to be healthy in theory, not taking risks with unhealthy behaviours, but the reality is that outside school, with the peer group, the situation changes and they behave the opposite. (Youth workers and health managers, 256–258)

Sex education continues to be a taboo subject among families, teachers and students. Some families think that it is not a good idea to deal with it in the school setting, because in many cases young people are immature and unprepared for it. Teachers feel obliged to focus their work on curricular subjects and achieving good academic results:

If I followed the school regulations I’m supposed to comply with, where I’m supposed to do the curriculum and nothing else, I couldn’t do anything else, well, I’d be off work with depression for sure. (A-Teachers, 990–993)

In this kind of context, teachers identified dealing with students’ health problems as an added difficulty, which generates enormous tension and overload: ‘If you saw the curriculum we’re supposed to follow, you can’t imagine it . . . We’ll all end up sick’ (A-Teachers, 965–966)

A more effective approach to health promotion would require a rethinking of subjects and the educational curriculum, and an increase in the amount of in-service education and training provided to teachers. Efforts might be made to integrate health and well-being into the curriculum as is reported to be happening in Wales (Llywodraeth Cymru [Welsh Government], 2019).

Discussion

In this study, secondary school students showed a satisfactory perception of health and well-being, with an average score of 80.9 points ($SD=12.5$). However, despite the fact that the average well-being score was high, with the standard deviation indicating that the data are spread close to the mean, the needs of the outlier subgroup should be taken into account. Attention should be given to improving well-being among the subgroup of students with the lowest scores.

Looking at health satisfaction by school year, the study showed that young people in the later years of secondary education perceived their health to be worse than those who were younger. This finding coincides with those from other studies carried out in Catalonia (González-Carrasco et al., 2019). More specifically, students’ decrease in perceived health during the first year of Baccalaureate is significant, since it is a full 10.8 points below the score recorded in the first year of secondary school (year 7). It also remains low in the second year of Baccalaureate. Respondents cited a number of factors that might lead to worse perceived health at this time. They include high educational demands and competitiveness from other students and those around them, including the school and the family. Second, stress and anxiety are caused by continuous preparation for exams, especially university entrance exams. According to Utzet and Salas (2018), 42.3% of young Catalans report

suffering from anxiety or depression, citing excessive academic demands and lack of time to study and finish schoolwork on time as the main reasons for this.

An additional factor affecting adolescents' health is a compacted school day, which favours sedentary behaviour with direct repercussions for health. Studies in Galicia (Cruz and Morán, 2016) and Andalusia (Ridao and Gil, 2002) have revealed that the compacted school day does not lead to improvements in students' daily habits. To sum up, educational demands at this time break the healthy habits cultivated and established earlier in education.

Although they were aware of students' health problems, teachers in this study pointed to a lack of accountability for health promotion among students. The priority in schools is for students to learn content, and this limits the attention they can give to health, which in many cases is left up to other professionals (Basch, 2011). Throughout Catalonia, teachers currently feel pressure to maintain and improve students' educational performance. This results in a focus on educational outcomes, to the detriment of health-oriented work (Jessiman et al., 2019). Health promotion is seen as an additional element that is not effectively integrated into the curriculum, and health activities are perceived as increasing teachers' workload and leaving them overwhelmed. Teachers also emphasised that they are not experts in health issues or even qualified to deal with them (Basch, 2011). Finally, a global or more holistic approach to health requires a rethinking of how subjects are taught and the educational curriculum as a whole.

The theoretical knowledge that young people possess regarding healthy behaviours often does not translate into self-care, making it difficult to adopt and adhere to a healthy lifestyle. Students frequently find themselves in a social environment where they do not have the ability to translate that knowledge into practice (Kelly and Barker, 2016). A particular challenge relates to students' low health satisfaction regarding their future security. In view of this, the school and family should work together to offer greater security in the present alongside a vision of a prosperous future security (Barry et al., 2017). According to McIsaac et al. (2015), one effective way of doing this is through the use of participatory pedagogies that integrate healthy attitudes, values and emotions, thereby generating an environment of esteem and security in the present while maintaining a positive vision for the future.

The results point to a paradox in social relations. Families and teachers signal that young people are at high risk of experiencing loneliness and isolation, while students themselves perceived high satisfaction with the groups of people they belonged to, as well as with their relationships with other people. Although attempted suicide and suicide have increased significantly among adolescents in recent years (Navarro-Gómez, 2017), this was not a topic touched on in the focus groups.

Study findings signal the importance of clear policy related to health promotion at schools not only at the school level but also at the municipal level where this work is much needed (Espluga et al., 2010). An adequate policy framework should stress the need to involve students, the school, the family and the wider community in the design and application of health policies with the aim of improving the health and well-being of the youth population. It should promote participation in accordance with a whole-school approach (Safarjan et al., 2013).

Conclusion


Findings from this study can be used to help improve health education throughout all the years of secondary schooling and provide professionals with data from which to design health and well-being actions that form part of a more holistic curriculum. They may also aid in the development of a system of indicators aimed at evaluating health promotion in secondary schools, signalling both the actions implemented by schools and the degree of improvement achieved through them in relation to health promotion.

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References

- Barry M, Clarke AM and Dowling K (2017) Promoting social and emotional wellbeing in schools. *Health Education* 117(5): 434–451.
- Basch CE (2011) Healthier students are better learners: High-quality, strategically planned, and effectively coordinated school health programs must be a fundamental mission of schools to help close the achievement gap. *Journal of School Health* 81(10): 650–662.
- Cala V, Ayala E and González A (2016) Adolescents perceptions of health education in secondary schools: The need for a dialectical, practical and transcultural proposal. *Practice and Theory in Systems of Education* 11(1): 27–35.
- Casas F, Tiliouine H and Figuer C (2013) The subjective well-being of adolescents from two different cultures: Applying three versions of the PWI in Algeria and Spain. *Social Indicators Research* 115: 637–651.
- Chilton R, Pearson M and Anderson R (2015) Health promotion in schools: A scoping review of systematic reviews. *Health Education* 115(3–4): 357–376.
- Clift S and Jensen BB (eds) (2005) *The Health Promoting School: International Advances in Theory, Evaluation and Practice*. Copenhagen: Danish University of Education Press.
- Creswell JW (2014) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. 4th ed. Thousand Oaks, CA: SAGE.
- Cruz L and Morán MC (2016) Jornada lectiva, aprendizajes y vida cotidiana del alumnado de Educación Secundaria Postobligatoria. *Revista Interuniversitaria de Formación del Profesorado* 86(302): 115–129.
- Díaz-Vicario A and Gairín Sallán J (2017) A comprehensive approach to managing school safety: Case studies in Catalonia, Spain. *Educational Research* 59(1): 89–106.
- Durlak JA, Domitrovich CE, Weissberg RP, et al. (2015) *Handbook of Social and Emotional Learning: Research and Practice*. New York: Guilford Press.
- Espluga J, Bosó A, Gallego L, et al. (2010) *Salut i joves: Dels contextos i les pràctiques de risc a les polítiques de promoció de la salut*. Barcelona: Departament d'Acció Social i Ciutadania. Secretaria de Joventut, Generalitat de Catalunya.
- European Union (2015) *Joint Report of the Council and the Commission on the Implementation of the Renewed Framework for European Cooperation in the Youth Field (2010-18)*. Brussels: Council of European Union, European Commission.
- González-Carrasco M, Vaqué C, Malo S, et al. (2019) A qualitative longitudinal study on the wellbeing of children and adolescents. *Child Indicators Research* 12(2): 479–499.
- Huber M, Knottnerus JA, Green L, et al. (2011) How should we define health? *British Medical Journal* 343: d4163.
- Jessiman PE, Campbell R, Jago R, et al. (2019) A qualitative study of health promotion in academy schools in England. *BMC Public Health* 19: 1186.
- Kelly MP and Barker M (2016) Why is changing health-related behaviour so difficult? *Public Health* 136: 109–116.
- Kok G, Gottlieb NH, Peters GJY, et al. (2016) A taxonomy of behaviour change methods: An intervention mapping approach. *Health Psychology Review* 10(3): 297–312.
- Langford R, Bonell C, Jones H, et al. (2015) The World Health Organization's health promoting schools framework: A Cochrane systematic review and meta-analysis. *BMC Public Health* 15: 130.

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- Leahy D and Simovska V (2017) Critical perspectives on health and wellbeing education in schools. *Health Education* 117(5): 430–433.
- Leger LS (2005) Protocolos y directrices para las Escuelas Promotoras de Salud. *Promotion & Education* 12(3–4): 214–216.
- Leger LS, Young I, Blanchard C, et al. (2010) *Promover la Salud en la Escuela. De la evidencia a la acción*. Saint-Denis: Unión Internacional de Promoción de la Salud y de Educación para la Salud (UIPES).
- Llywodraeth Cymru (Welsh Government) (2019) Draft curriculum for Wales 2022: A guide to curriculum for Wales 2022. Available at: <https://hwb.gov.wales/draft-curriculum-for-wales-2022>
- McIsaac JL, Storey K, Veugelers PJ, et al. (2015) Applying theoretical components to the implementation of health-promoting schools. *Health Education Journal* 74(2): 131–143.
- Mohamed S (2015) *Factors Influencing the Implementation of Health Promoting Schools: A Multiple Case Study of Three Secondary Schools in a Resource Limited Community in Cape Town*. Cape Town, South Africa: Health Community and Health Sciences Faculty, University of the Western Cape.
- Murray NG, Low BJ, Hollis C, et al. (2007) Coordinated school health programs and academic achievement: A systematic Review of the literature. *Journal of School Health* 77(9): 589–600.
- Navarro-Gómez N (2017) El suicidio en jóvenes en España: cifras y posibles causas. Análisis de los últimos datos disponibles. *Revista de Psicología Clínica y Salud* 28(1): 25–31.
- Nutbeam D (2018) Health education and health promotion revisited. *Health Education Journal* 78(6): 705–709.
- Organisation for Economic Co-operation and Development (OECD) (2015) *Skills for Social Progress: The Power of Social and Emotional Skills*. Paris: OECD Skills Studies, OECD Publishing.
- Pearson M, Chilton R, Wyatt K, et al. (2015) Implementing health promotion programmes in schools: A realist systematic review of research and experience in the United Kingdom. *Implementation Science* 10: 149.
- Ridao I and Gil J (2002) La jornada escolar y el rendimiento de los alumnos. *Revista de Educación* 327: 141–156.
- Safarjan E, Buijs G and de Ruiter S (2013) *Manual escolar online de SHE. 5 Pasos hacia una escuela promotora de salud*. Utrecht: CBO.
- Salvador T (2008) *Informe: Diagnóstico de situación sobre avances conseguidos, necesidades y retos en promoción y educación para la salud en la escuela en España*. Madrid: Ministerio de Sanidad y Consumo.
- Santelli J, Vernon M, Lowry R, et al. (1998) Managed care, school health programs, and adolescent health services: Opportunities for health promotion. *Journal of School Health* 68(10): 434–440.
- Suhrcke M and de Paz Nieves C (2011) *The impact of health and health behaviours on educational outcomes in highincome countries: a review of the evidence*. Copenhagen: WHO Regional Office for Europe.
- Sulz L, Gibbons S, Naylor PJ, et al. (2016) Complexity of choice: Teachers' and students' experiences implementing a choice-based comprehensive school health model. *Health Education Journal* 75(8): 986–997.
- Utzet M and Salas S (2018) Salut. Una aproximació a l'estat i els hàbits de salut de la joventut i als factors que la determinen. In: Serracant P (ed.) *Enquesta a la Joventut de Catalunya 2017* (Experiències juvenils i desigualtats socials), vol. 2. Barcelona: Departament de Treball, Afers Socials i Famílies, Generalitat de Catalunya, pp. 51–85.
- Vega A, Aramendi P, Buján MK, et al. (2014) La educación para la salud en la ESO: Aportaciones de un estudio sobre el País Vasco. *Educación XXI* 18(1): 167–188.
- Whitman CV (2005) Implementing research-based health promotion programmes in schools: Strategies for capacity building. In: Clift S and Jensen BB (eds) *The Health Promoting School: International Advances in Theory, Evaluation and Practice*. Copenhagen: Danish University of Education Press, pp 107–136.
- World Health Organization (WHO) (1986) *The Ottawa Charter for Health Promotion*. Geneva: WHO. Available at: <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html> (accessed 12 March 2019).
- Young I (2005) Health promotion in schools – A historical perspective. *Promotion & Education* 12: 112–117.