

Student participation: a democratic education perspective—experience from the health-promoting schools in Macedonia

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Abstract

The paper addresses the issue of student participation from the perspective of the health-promoting schools initiative. It draws on experience from the Macedonian Network of Health-Promoting Schools and its collaboration with the Danish as well as other country networks within the European Network of Health-Promoting Schools. Student participation is viewed as one of the main focal points of the conceptual framework and model of a health-promoting school developed within the Macedonian context. This model and the model distinguishing between two different qualities of participation—genuine and token participation—are presented and discussed in the paper. Underpinning values that these models endorse as important for the processes of health promotion in schools include self-determination, participation, democracy, diversity and equity.

Introduction

The European Network of Health-Promoting Schools (ENHPS) is a joint initiative of the WHO, Commission of the European Communities and the Council of Europe. It was first launched at the beginning of the 1990s with an

aim to initiate, test, evaluate and disseminate through model schools, innovative, school-based health-promoting processes (WHO, 1993). The concept of health promotion has since become a well-established framework for the development of school-based approaches to health promotion in a number of countries. At present the ENHPS consists of more than 40 countries, approximately 500 directly involved schools with 500 000 students and 10 000 teachers, and more than 2000 additional schools involved indirectly through various national and regional arrangements.

The health-promoting schools approach brings together the strategic guidelines outlined in the Ottawa Charter (WHO, 1986) and the principles stated in more recent WHO documents, e.g. *Health 21—Health for All in the 21st Century: The Health for All Policy Framework for the WHO European Region*, which sets out targets for health for all in the 21st century. *Health 21* draws on the values of health for all, including, for example, health as fundamental human right, equity in health, and participation of individuals, groups, institutions and organizations in health promotion. One of the key strategies that this policy document emphasizes is a participatory health development process that involves relevant partners for health, at all levels—home, school and worksite, local community and country—and that promotes joint decision making, implementation and accountability (WHO, 1999).

The principles that are particularly related to the health-promoting schools initiative, as they were discussed and adopted at the First Conference of the ENHPS, include democracy,

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equity, empowerment and action competence, school environment, curriculum, teacher training, measurement of success, collaboration, communities, and sustainability (WHO, 1997). These principles clearly indicate a move away from the traditional, disease-oriented medical approach to health promotion, towards an empowering, social model. Health promotion in schools is construed as a social process of individual and collective empowerment. Health is interpreted positively and holistically, encompassing the dimensions of physical, social, emotional, spiritual and mental well-being. Consequently, the development of an individual's skills, self-determination and agency is considered within a given context, in connection with the health-related conditions. The aim of the health promotion is constructed as providing conditions for improving one's control over social, structural and systemic determinants of health rather than modifying individual lifestyles.

In reality, however, the concept of a health-promoting school has been construed differently in different contexts, thus obtaining a wide range of meanings. A number of 'models' of health-promoting school have emerged over the previous years reflecting different educational priorities and ideologies, needs, as well as systems of meaning within the national networks (Jensen and Simovska, 2002). The ideology underpinning the health-promoting school is always controlled by elements of professional power and the need for public accountability (Denman *et al.*, 2002).

Health-promoting schools in Macedonia

Macedonia joined the ENHPS in 1995 with 10 elementary schools. Since then the national network of health-promoting schools [Macedonian Network of Health-Promoting Schools (MNHPS)] has been established and structured in three 'rounds' of schools, of which 34 are elementary and six secondary. The number of students participating in school health-promoting activities

is approximately 25 000, and the number of involved teachers and other school staff is about 1500.

Team of researchers (including the author) from the University in Skopje were asked by the national coordinator of the MNHPS to act as an 'expert team' for the project, and help in conceptualizing and shaping the process of health promotion in schools. This involved regular visits to schools and often facilitating student health-promoting activities together with teachers. The team was also responsible for project-based in-service training for teachers. This included regular workshops and seminars where conceptual issues such as student participation, action and action competence were considered, and specific action plans for their implementation in school projects were made. In addition, the experiences of linking theory and practice were discussed regularly on monthly meetings with the school coordinators. This involvement in the educational development process provided the basis for an intensive, longer-term dialogue between the researchers and practitioners, and further conceptualization of the experience gained through the health-promoting school actions, a result of which are the models presented in this paper.

In accordance with main ENHPS principles (WHO, 1993, 1997) the health-promoting school is defined as an educational setting that attempts constantly to develop its capacity for healthy learning, working and living. The whole school environment is seen as important area to be dealt with if a school is to be health promoting. That actually means that emphasis is placed not exclusively on teaching and learning processes, but also on the whole school atmosphere including relationships, management structures and physical environment. It is considered important that a health-promoting school operates as a 'learning' and 'growing' organization, where students learn and develop their skills and competencies in classrooms, but also in everyday school life, including overall strategies for making decisions, social relationships at school and the use of resources.

The main characteristic, and perhaps specific to the Macedonian health-promoting schools project, is that it represents a broad frame for rethinking and redefining not only the traditional approach to health education, but also fundamental educational philosophy. The underpinning philosophy of the Macedonian health-promoting schools approach is characterized by the move towards a more democratic and inclusive school as opposed to the traditional didactic paradigm. An important feature of this is the attempt of the health-promoting schools to work in an action-oriented way. In other words, this means that health-promoting schools aim at development of students' 'action competence' (Jensen, 1997), which refers to their ability to influence their surroundings, initiate positive change and make a difference. This interpretation of the health-promoting schools approach is closely related to both the social model of health (Kickbusch, 1991), which interprets health as being influenced by multifaceted factors (political, environmental, psychological, economical and biological) and the radical educational discourse that addresses issues of empowerment through education (Tones and Tilford, 1994; Katz and Peberdy, 1997).

Action competence is considered to be an 'educational ideal' within a humanistic, democratic and critical education theory, particularly in Denmark (Schnack, 2000). Within the health education and health-promoting schools initiative, the concept of action competence is operationalized through several components, such as knowledge, commitment, vision and action experience (Jensen, 1997).

Jensen's criticism of the behavior-change-oriented health education echoed in the Macedonian context, and was adopted and adapted to the development of the Macedonian model of a health-promoting school. All the schools within the MNHPS worked with the IVAC (Investigation–Vision–Action–Change) approach (Jensen 1997), designed to strengthen student participation and help teachers structure health-promoting activities in school. A variety of projects were undertaken in schools using this approach, directed towards

encouraging students to envisage positive change and take action to promote health. The approach was adjusted to the specifics of the Macedonian context. For instance, 'Selection' and 'Evaluation' aspects were added with a view to strengthen students' participation in selection of the health issues as well as to encourage student involvement in evaluating their own actions. Thus, the IVAC approach became 'S–IVAC–E'. Examples of school-based actions taken by students include: improving the school environment, establishing a school radio, setting up peer health education ('learning through teaching') and introducing democratic mechanisms in school [more examples from the Macedonian health-promoting schools can be found in (Simovska and Cheshlarov, 2001)].

The key aspects of the conceptual foundation on the Macedonian health-promoting schools approach include (Simovska and Kostarova-Unkovska, 1998):

- Providing opportunities for students' participation in school life and broadening the scope of action experiences.
- Promotion of mental and emotional well-being of students and school staff.
- Improvement of schools' readiness to respond sensitively in crisis situations or development of schools' 'organizational resilience' (Simovska and Sheehan, 2000).

These aspects have been further developed and embedded into the Macedonian model of health-promoting school.

Main components of a health-promoting school

The model presented on Figure 1 has been developed primarily with an aim to map the past–present–future line in the project development, and to serve as a source of inspiration and debate in further development and conceptualization of the concept of health promotion in schools in Macedonia. It is considered as a reflection tool to guide health-promoting schools activities

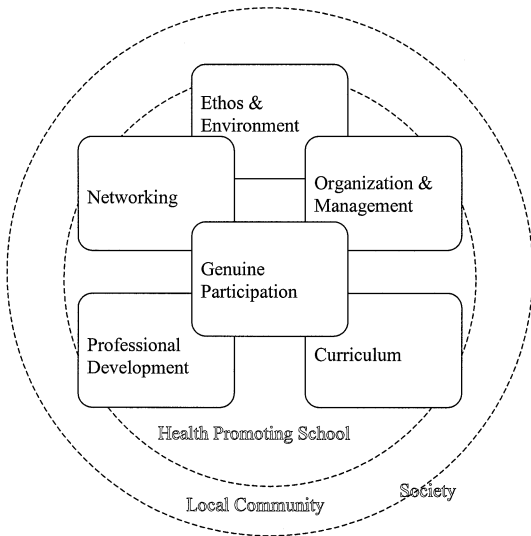


Figure 1. Main components of the health promoting school in Macedonia [source: (Simovska *et al.*, 2002)].

nationally, rather than as fixed model to be accepted and implemented as such. The model components and their complex relations change over time, depending on the broader conditions in the society and current focus of the project at a given time/region/school.

One of the specific outcomes of the conceptual developments of the health-promoting school in Macedonia is the new health education curriculum, which emphasizes democratic, participatory teaching strategies and introduces the IVAC approach as a central teaching approach (Ministry of Education of the Republic of Macedonia and the Bureau for the Development of Education, 2001).

As shown in Fig. 1, different components of the model are presented with several overlapping layers, indicating that the ‘whole is more than the sum of its parts’. This actually emphasizes that the health-promoting school represents a complex, reflective and dynamic system consisting of the following intertwined elements:

(1) A shared vision about the aim of the school and common values that are to be endorsed through schooling (*school ethos*). Some of the underpinning values that the Macedonian network of health-promoting schools attempts to actualize

are the following: democracy, equity, safety, self-determination and participation. Within the Macedonian context, these values are related to the overall post-communist transition and value transformation in the society as a whole. Given the large political and economic instability that the country has been facing over recent years, these value actualization processes in schools are even more complex than usual. However, the Macedonian health-promoting schools attempt to take up the challenge and initiate structural change. The most recent example of the attempt to actualize some of these values is the programme ‘Safe school in a risk community’ undertaken in schools with both Albanian and Macedonian students in one of the multi-ethnic communities in the country. The programme’s aim is to engage students in promoting non-violent ways of solving conflicts in school, and developing mutual respect and trust between the two communities in conditions of ethnic tensions and military crisis in the country (Egumenovska and Gjoric, 2002).

- (2) A physical as well as psychosocial school *environment* conducive to promoting health. Physical environment includes flexible and safe school buildings and facilities, adjusted to students’ aesthetics as well as to participatory teaching. Psychosocial environment includes the ‘feeling’ of the school, the extent of social connectedness and respect for differences, styles of communication and conflict management at school, and care for the well-being of students as well as school staff.
- (3) Genuine student *participation* and action competence development.
- (4) A process-oriented, transparent and critical *curriculum*, which takes its starting point in a holistic view on health and participatory teaching strategies.
- (5) Relevant *professional development* for teachers and school staff, particularly with regard to student-oriented teaching methods that build on students’ potential and ideas.

- (6) Democratic, participatory and transparent school *management*.
- (7) A sensitive and efficient *crisis intervention* policy, in case of individual as well as collective crisis situations. The refugee crisis in a number of Macedonian schools following the war in Kosovo as well as during instabilities in Macedonia was the most recent demonstration of the importance for this aspect to be integrated in the Macedonian model of health-promoting school.
- (8) *Collaboration and networking* on different levels (local, national, international).
- (9) *Conditions* in the local community and broader society, effective partnership of relevant sectors as well as overall 'change-friendly' surrounding culture.

The interplay of these components determines the profile and specific nature of a health-promoting school, and at the same time reflects the conditions in the broader community.

In the following section the focus is placed on the issue of student participation, which is considered the central component in the model. For more detailed discussion on the other issues in the model, see Simovska *et al.* (Simovska *et al.*, 2002).

Participation and democracy

Arguably, one of the key elements of a health-promoting school is appropriate 'space' for the students to participate genuinely in relevant aspects of decision-making processes at school. A participatory approach to health promotion implies more than the improvement of the health status of individuals in a given school community. Health-promoting schools should provide resources and possibilities for students to develop, promote, exercise and exert their competencies to be qualified participants in democratic environments. In other words, a health-promoting school aims at developing students' action competence (Jensen, 1997).

Given this perspective, participation presupposes improving students' self-awareness, deci-

sion-making and collaboration skills, connecting students among themselves and with the school, and empowering both students and school communities to deal with health issues (Simovska, 2000). In this way the health-promoting school approach addresses the issues of democracy, empowerment and action competence. This implies the controversial process of challenging the traditional power imbalances in schools.

Some decades ago, a number of authors [e.g. (Arnstein, 1969; Brager and Sprech, 1973)] developed useful typologies of participation, based mainly on distinguishing between different degrees of power and influence that is shared. However, these models do not address directly the participation of children and young people, which is quite specific, even though originating from the same theoretical principles. Used quite frequently over recent years, the notion of 'children participation' has obtained a variety of, sometimes contradictory, meanings. Sometimes it means involvement of children in different groups or activities. In school environments it is often used to refer to the interactivity and playfulness of teaching strategies. Sometimes it simply means taking part in discussions and debates, while, on other occasions, it implies sharing power in making decisions. Hart strongly underlines the connection between participation and democracy, and interprets participation as the 'fundamental right of citizenship' [(Hart, 1992), p. 5]. Arguably, the question of authentic teaching *with* and *in* democracy as opposed to teaching *about* democracy is essential not only for traditionally authoritarian educational systems of the 'new democracies' (e.g. the eastern and central European countries), but also for the so-called 'developed democracies'. As Hart continues [(Hart, 1992), p. 5]:

... An understanding of democratic participation and the confidence and competence to participate can only be acquired gradually through practice; it cannot be taught as an abstraction. Many western nations think of themselves as having achieved democracy fully, though they teach principles of democracy

in a pedantic way in classrooms which are themselves models of autocracy. This is not acceptable.

Democracy is primarily participation and therefore education for democracy actually means qualification for the role of a competent participant (Schnack, 2000).

Participation, meaning and learning

Authentic student participation in school processes is also an essential element of personally meaningful learning. The quality of learning that takes place through students' participation could be best described with the term *appropriation*, as it is used in ecological dynamic psychology, inspired by the ideas of holism of Lewin (Lewin, 1926) and the sociocultural theory of Vigotsky (Vigotsky, 1978), among others. This sociocultural perspective suggests that processes of learning and development should draw attention to how personal efforts, interpersonal relationships and culturally structured activities constitute each other. This means that it would not be sufficient to focus on individual learning or competence development without any concern for the interpersonal relationships as cultural activities in which learning and development are taking place. Rogoff [(Rogoff, 1993), p. 138], for instance, argues that appropriation is a process that occurs in the context of engagement (often with others) in sociocultural activity, but focuses on personal processes of transformation that are part of an individual's participation. While personal processes are treated as a foreground, the purpose is to analyze them without losing track of the interdependence of other individuals, social relations, historical traditions and cultural contexts. Appropriation is a process in which individuals participating in an action change so they can more easily handle further actions and interactions. Rogoff points out that appropriation is different from 'internalization'—a term which is often used in psychological theory to explain how children gain from their involvement with others in

sociocultural activities. The notion of internalization is more static; it means that children make external things internal, while appropriation is participatory. Children 'must already be functioning in the social activity in order to be making their contributions' [(Rogoff, 1993), p. 139], and that is how they develop insights, skills and competence.

This brings to the fore the importance of interpersonal relationships in facilitating relevant student participation in school learning. Particularly important are relationships with teachers and other adults, or 'more experienced participants', as they play important roles as facilitators of learning in the zone of proximal development (ZPD) (Vigotsky, 1978). Such relationships form a kind of developmental infrastructure on which school experiences build (Pianta, 1999). Experience must be related before it can be conceptualized. Therefore, teachers need to be aware of educationally critical aspects of students' experiences and build participatory situations around them. In other words, relationships constitute part of a specific quality of the ZPD, which could be more or less conducive to learning and enhancing students' competencies.

The core of the participatory health education and health-promoting school is, therefore, intersubjectivity and the participation-in-meaning. It is essential that through participation students try to create meaning for the actions in which they participate. The process of the creation of meaning is taking place while they actively search for common ground with other participants in culturally organized activity. Thus, participation in dialog, and reflecting on and constructing shared meanings about health problems, their causes and strategies for solutions are equally important in the development of action competence as is undertaking specific actions. Dialogue and action are, of course, inextricably intertwined. Nevertheless, it is necessary to emphasize the importance of student participation in dialog, particularly since the dialogue remains inherent in teaching and school processes in general as well as in action-oriented teaching.

Two different qualities of participation

As a result of the experience obtained through intensive collaboration with the MNHPS and on the basis of Hart's ladder of participation (Hart, 1992, 1997), two distinctive qualities of student participation were identified. For the purpose of conceptual analysis, they were named, provisionally, token and genuine participation. As mentioned earlier, the model has been developed in the process of continuous dialogue with teachers and students involved in the MNHPS. Unlike Hart's ladder, which sets up more procedural democratic criteria for distinguishing participation from non-participation and describes five different degrees of participation (Hart, 1997), this model focuses on the quality of participation apart from its presumed position on the ladder (the participation part). The binary distinction of two forms of participation was considered a useful tool for Macedonian teachers to help them clarify their teaching aims when working with participatory approaches, with a view to move away from the traditional, behavior modification teaching.

Genuine participation is seen to be conducive to the personally meaningful learning and development of action competence. Illustrative of the distinction between these two qualities of participation is Jensen's (Jensen, 1994) claim regarding democratic versus moralistic approaches in health education. These forms of participation are fundamentally different and mutually exclusive. This particular categorization of the two forms of participation deals with values, often implicitly embedded in socially organized participatory activities involving students at school. As mentioned earlier, the underpinning values or prin-

ciples that this model endorses as important for the processes of health promotion in schools include self-determination and participation, democracy, diversity, and equity. A genuine participative approach to health education and the health-promoting schools holds the potential for more balanced actualization of these values, at least at the school level. However, we need to keep in mind the complexity, context dependence and dynamic character of the value-implementation processes, especially in the Macedonian educational context, where strong power hierarchies and resistance to change traditionally exist.

As presented in Table I, the first point of differentiation is the *focus* of the health-promoting activities in which the students participate. A token participation would have its focus on contents that have to be learned, accepted and used. In the health-promoting school context, such content involves traditional facts related to health and hazardous effects of different behavior styles. Students do not have much influence on the knowledge with which they are supposed to work. However, they participate in an interactive methodology that helps them acquire that knowledge. Genuine participation, on the other hand, focuses on reflection on personal meanings and on different ways of constructing knowledge about health. Facts are being learned too, but it is the processes that lead to their discovery and their complex connectedness in a system of economical, historical and ideological aspects that are considered essential.

In the discussions held in a number of in-service training workshops, teachers from the Macedonian health-promoting schools basically agree that the so-called active-learning methodology (relatively new in Macedonian schools), which strongly

Table I. Three points of differentiation between token and genuine student participation

	Token participation	Genuine participation
Focus	content, consequences, effects	reflections, personal meanings, social construction
Outcomes	convergent (ready made lifestyles, healthy behavior)	divergent (critical consciousness, responsible freedom)
Target	individuals	individuals-in-context

emphasizes student active involvement, provides token participation because it does not challenge the view of learning as primarily a reproducing process. That is particularly true within health education, and a number of smoking, drug, alcohol and HIV education programs, overloaded with information, illustrate this point. Student participation is seen merely as a motivational tool. Nevertheless, experience from health-promoting schools that rely on genuine student participation shows that it is possible, and in the long run more conducive to health, to build on the view of learning as a process primarily seeking and constructing meaning, as seeing something from different perspectives (Marton and Booth, 1997) and changing as individuals while initiating changes in the surrounding environment. The development of competence to act intentionally requires not only knowledge, but also the ability to regulate one's own cognition and action in a way that identifies and makes use of the potentials and possibilities of the environment.

The second point of differentiation is in the *outcomes* of the health-promoting school activities. Outcomes of token participation could be defined as acceptance of pre-existing ('ready-made') healthy lifestyles that correlate with facts describing what is healthy and what is not. Outcomes are closed or convergent. Rules in regard to health are fixed, prescribed by experts on the base of scientific evidence, and there is not much room for personal choice and determination. Student participation would mean active exercise in making 'healthy' decisions, and developing assertive and other personal and social skills in order to avoid the 'negative' pressures of other classmates, peers, media, etc. In terms of genuine participation, again, the aims would be to enhance students' autonomy, critical consciousness and their potential to deal with complexity of their own lives and the world in a creative, free and socially responsible way. Consequently, outcomes would be open and divergent, depending on the ideas and interests of individuals or groups of students, as well as on the constellation of power relations, needs and

possibilities of a particular school environment at given moments.

A good example of this distinction can be seen in the concerns voiced by teachers about students in one of the Danish health-promoting schools smoking in the schoolyard while participating in the school health-promoting actions. The teachers expressed the hope that these students would 'decide for themselves' (Wessing Film-TV, 1997). Another example from Macedonia also illustrates this point (Jankuloska and Poposka, 2001). When asked what should be changed in the school in order to make it 'healthier', students in one of the health-promoting schools chose to plan and carry out an action that would shorten the lessons from 45–40 min. For the students this issue was linked to health, and they were able to articulate and defend their position by relating it to more time for sports in the middle of the school-day, better possibilities for socializing, a more relaxed time during the lunch break and so on. All those issues are indeed health-related, although, at the beginning, it was difficult for some of the teachers to see this because they were used to thinking in terms of prescribed health curriculum topics. In both of these contexts, and according to teachers, the challenge of having 'doors open' for an authentic follow-through on students' recommendations and taking the students' ideas seriously was highly demanding, but at the same time exciting and rewarding.

The third point of differentiation between the two forms of participation is the *target of change* of the participatory activities. Token participation tends to target individuals, while within genuine participation the target would be individuals-in-context. In the latter, individual behavior becomes linked with interpersonal involvements and organizational structures in a gestalt. In some of the Macedonian health-promoting schools, for instance, where the focus was on mental health, the model of mental health promotion employed attempted to provide possibilities for students to participate in initiating changes in school organizational and interpersonal issues (Simovska and Sheehan, 2000). It was considered inappropriate

ate to assume that improvement of self-esteem, self-confidence or emotional intelligence occurs at the level of the individual only. On the contrary, the starting point was that students' competencies are not only their own property. Development of skills and competencies embraces processes that occur at three levels—personal, interpersonal and cultural. Students are as competent as their context (school in this case) affords them the opportunity to be (Pianta, 1999) and, at the same time, they are able to influence these circumstances. Thus, it could be argued that if students have opportunities to participate genuinely in influencing their surroundings as part of their education and so be agents of their own learning, they are enabled to assume responsibilities for their own lives and also to participate competently in the social web.

It is important to underline, however, that identification and/or operationalization of the specific components of action competence would be different in different contexts in spite of the fact that the basic principles remain the same. Moreover, distinguishing token from genuine participation is a complex process that needs more sophisticated approaches to evaluation. This is particularly the case with respect to the refinement and development of new participatory evaluation methods that allow for students' involvement in defining the indicators for success and their assessment at the school level. These new approaches should not remain at the level of academic exercises only. Rather they should really provide space for the voices and choices of young people. Some attempts with this regard have been undertaken within the Danish and Macedonian health-promoting school network (Jensen and Kostarova-Unkovska, 1998), but there still remain a number of challenges to be faced, a discussion of which is beyond the scope of this paper.

Arguably, the health-promoting schools that are based on genuine participation hold a potential to reach a better balance between so-called individualistic and structural approaches to health promotion in schools. Health and health promotion are seen holistically without neglecting either the environment and health conditions or the individ-

ual and the importance of personal meanings. In the spirit of Vygotsky [in (Holzman, 1997)], a student participating genuinely in school health-promoting processes is looked upon not as an individual, but rather as a 'person-and-environment', where the school and the environment are not abstractions, but real entities consisting of real people. Consequently, indicators for successful learning about health would not be only what a student knows, but rather what she/he wants to and can do alone or in collaboration with others.

Endnote

As Jantsch claimed two decades ago [in (Polan, 1989)], the three qualities of the new paradigm of evolution are: intensity, autonomy and meaning; from this standpoint, we stand at the point of an extraordinary *intensification* of life. These qualities, along with the differentiation and complexity of society, inevitably put forward the values of democracy and participation.

Schools as educational social institutions are in an excellent position to endorse these values, and 'educate' young people to be competent, creative and responsible participants in such a society. Consequently, student participation has become an inevitable part of any discussion regarding education in general, as well as health education and health promotion at school. At the same time, health-promoting school processes are rather complex issues and so is student participation. More research is needed to explore numerous aspects that can contribute to the development of more sophisticated teaching and learning strategies, which accentuate care and empowerment rather than control of students.

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