Chapter 4
Learning *in* and *as* Participation: A Case Study from Health-Promoting Schools

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Keywords learning, student participation, health education, health-promoting schools, action competence

4.1 Introduction

Drawing on theoretical discussion and the vitality of an empirically-based case study, this chapter documents, explores, and reflects on processes of learning about health through participation and action. The study is positioned within the democratic health-promoting schools tradition which emphasises a critical approach to the issue of student participation and the importance of taking action as part of learning about health. The chapter begins with discussion of the health-promoting schools initiative in Europe as exemplified by the European Network of the Health Promoting Schools, the position of the concept of participation within the frames of the health-promoting schools approach, and its implications for the ways we look at learning. Then, a model distinguishing two different qualities of participation, (token and genuine), is considered. The model builds on two complex sets of theoretical concepts – the democratic approach to health-promoting schools on the one hand, and the sociocultural perspective on learning on the other. The model is used as the main analytical framework in the case study. The findings from the case study are discussed in several sections, shedding light on the different processes of knowing in which students were involved. This includes illuminating the forms of peer collaboration and mutual interactions as well as the activity structures and forms of participation in which students were engaged, e.g. investigations, identifying problems, solution ideas, and taking action to bring about changes with respect to two overall health topics. At the end of the chapter, a few dilemmas and challenges for future research arising from the study are outlined.

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A. Reid et al. (eds.), *Participation and Learning*, 61–80.

4.2 Health-Promoting Schools, Participation and Learning

The core principles underlying the health-promoting schools initiative as discussed and adopted at the first two conferences of the European Network of Health Promoting Schools (ENHPS) include: *democratic practices, participation and partnership; equity and access; empowerment and action competence; safe and supportive school environments; curriculum* (health knowledge and understanding as well as health-promoting teaching and learning methodologies); *teacher training; evaluation for building on successes; collaboration with stakeholders, communities and parents*; and *sustainability* (WHO 1997, 2002). These principles clearly indicate a move away from the traditional, disease-focused approach to health education and health promotion, towards an empowering, social model. 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, such as Health 21 – the Health for All policy for the WHO European Region, which sets out targets for the 21st century. Health 21 draws on the values of health for all, including, health as a fundamental human right, equity in health, and participation of individuals, groups, institutions, and organisations in health promotion. One of the key strategies that this policy document emphasises is a participatory health development process that involves relevant partners for health, at all levels – home, school, and workplace, local community and country – and that promotes joint decision-making, implementation, and accountability (WHO 1999).

Accordingly, health promotion in schools is construed as a social process of individual and collective empowerment. A health-promoting school is defined as an educational setting that attempts to constantly develop its capacity for healthy learning, working, and living (WHO 1993). Health is interpreted positively and holistically, encompassing the living conditions related to health as well as dimensions of physical, social, emotional, spiritual, and mental well-being. The development of an individual's skills, self-determination and agency with regard to health matters is always considered within a given context in connection to the surrounding living conditions. The whole-school environment is viewed as an important arena for promotion of health and for learning about health.

Interpreted in this way, the health-promoting schools approach inevitably brings the issue of meaningful student involvement in teaching and learning processes to the fore. Moreover, 'student participation' has become one of the trendy, captivating terms within the ENHPS, holding the central position in portraying the health-promoting schools initiative. In reality, however, the ideology underpinning the health-promoting schools initiative is to a large degree influenced by elements of professional power and the need for public accountability (Denman *et al*. 2002). The concept of health-promoting schools has been interpreted differently in different cultural, geographical, and educational contexts and thus obtained a wide range of, sometimes contradictory, meanings (Simovska 2000). A number of models of health-promoting schools have emerged over recent years reflecting different

educational priorities, ideologies, needs, and systems of meaning within the national networks (Jensen and Simovska 2002). Often, in spite of or parallel to the rhetoric emphasising participatory and empowering nature of the health-promoting schools approach, the practice remains dominated by a behaviouristic paradigm focusing primarily on individual students and modification of their lifestyles.

One of the significant challenges to the behaviouristic perspective is characterised by the distinction between 'moralistic' and 'democratic' health education and health promotion conceptualised within the Danish Network of Health Promoting Schools (Jensen 1997). The democratic perspective suggests that it is important that a health-promoting school accepts the challenge to revisit its structures and environment and improve its potential to enhance students' capacities for visionary thinking and social responsibility, and their competence to tackle health-related problems. This is instead of endorsing empty participationism while aiming solely at knowledge transmission and behaviour change. Thus, the main aim of democratic health-promoting schools is construed as the development of students' action competence, that is, the ability to act and bring about positive change with regard to health. Action competence is operationalised through integration of cognitive and affective components such as knowledge, commitment, visions, and action experiences (Jensen 2000, 2004). Participation is interpreted as a transformative process focused on making a difference, as opposed to conforming to the status quo. It is viewed in connection to the characteristics of the school environment, e.g. in terms of appropriate democratic and inclusive structures, supportive relationships, positive social norms and values, opportunities for achieving success and developing skills and competences, and so on. Accordingly, one of the key tasks of a democratic health-promoting school is providing an appropriate space for students to participate actively in relevant rather than trivial aspects of decision-making processes at school. Moreover, it is considered essential that a health-promoting school should ensure resources and opportunities for students to develop, enhance, exercise, and exert their competences to act as qualified agents in democratic environments. This presupposes fostering students' self-awareness, critical thinking, decision-making, and collaboration skills, connecting students among themselves and with the school, and empowering both students and school communities to deal with health determinants and other health matters that concern them (Simovska 2000).

Thus, the democratic approach to health-promoting schools can stimulate the introduction of fundamental changes to school approaches to teaching and learning as well as school management, which move away from top-down hierarchical school structures towards more participatory and empowering systems on all levels. Consequently, as will be discussed in what follows, this perspective points to controversial processes of challenging traditional power imbalances in schools and also implies a different view of the nature of learning. Both taking into account the whole-school environment along with the classroom as an arena for learning, and highlighting the close links between the school, the family, the local community, and society at large, emphasises a view of learning as situated in a sociocultural context and located in processes of participation or co-participation rather than solely with the individual.

When we think about participation from a variety of perspectives in learning theory, the meaning of it varies substantially (see Table 3.1, and Reid and Nikel's discussion of

learning theory and participation in Chapter 3). Conventional learning theories typically attempt to explain the ways individuals learn and to discuss the implications of these explanations by considering teaching strategies that would foster an isolated individual's learning. In contrast, the sociocultural theory of learning and development inspired by the ideas of Vygotsky, among others, interprets learning as a profoundly social process, linked closely to the processes of psychological development. The central educational concept in Vygotsky's theory (1978) is the concept of the zone of proximal development (ZPD), i.e. the distance between the actual and the potential developmental level. While the actual developmental level is determined by independent learning, the potential level is determined by the amount of guidance, from adults or more experienced peers, needed in problem solving. The ZPD concept points to a change of focus in learning theories, suggesting deeper consideration of the interaction between cognition, context, and practice. The change in focus also includes that the unit of analysis is not the individual but the dynamic integration of the individual and the social environment; this change radically reorients learning theory from an individualistic to a relational and sociocultural perspective. The following oft-cited words of Vygotsky (1978:57) highlight his view on the essentially social nature of psychological development, which has profoundly influenced theories of learning:

> Every function in the child's cultural development appears twice: first, on the social level, and later on the individual level; first, *between* people (*interpsychological*) and then *inside* the child (*intrapsychological*). All higher functions originate as actual relations between human individuals.

The developmental processes become part of the individual's independent development through the processes of internalisation, or as suggested in latter interpretations of Vygotsky's theory (e.g. Rogoff 1995; Rogoff *et al*. 2001), through the processes of appropriation. Appropriation refers to a personally active – and at the same time – multidirectional process; it indicates that new knowledge and competence are actively transformed rather than simply interiorised by the learner. The process of guided participation provides link between previous experience and competences and the skills and information needed to solve new problems (Rogoff 1993; Rogoff *et al*. 2003). Intersubjectivity and participation-in-meaning are therefore considered to be core elements of participatory learning. These two concepts serve to emphasise that creation of meaning and understanding is relational, that is, it happens between people (see, for example, Chapter 8 by Vare, this volume). Both the concepts of intersubjectivity and participation-in-meaning refer to a process in which participants reach an agreement and common, dialogical understanding of actions with which they are faced. In this perspective, knowledge is interpreted as a social process of knowledge construction rather than an object for students to internalise. Meaning and knowing are negotiated and dynamically created and re-created through participation in socially organised activities. Accordingly, both authentic student participation in teaching and learning processes and social guidance that builds on students' perspectives, are considered essential dimensions of personally meaningful learning.

Thus, in the context of health-promoting schools, one can argue that participation in dialogue, changes of perspective, reflecting on, and co-constructing shared meanings

about health problems, their determinants and strategies for solutions, are equally important in the development of action competence as undertaking specific actions.

4.3 Token and Genuine Student Participation

Inspired, on the one hand, by Hart's categorisation of participation into different levels illustrated by the metaphor of the ladder (Hart 1992, 1997), and on the other, by the sociocultural perspective on learning as an underlying theoretical framework, two distinctive qualities of student participation are identified in this chapter by drawing on the experience from the Macedonian Network of Health Promoting Schools and its collaboration with other networks of the ENHPS, namely: *token* and *genuine* student participation. Unlike Hart's ladder which sets up more procedural democratic criteria for involving children and distinguishing between different degrees of participation, this distinction focuses on the quality of participation apart from its presumed position on the ladder (the participation part). It deals with values which are often implicitly embedded in socially organised participatory activities involving students at school but repeatedly neglected when researching the processes of teaching and learning. The underpinning values or principles that this distinction endorses as essential to participatory health education and health promotion in schools include self-determination, democracy, and diversity (Simovska 2000, 2004). As presented in Figure 4.1, three main points serve to differentiate between token and genuine student participation: *focus, outcomes*, and *target of change*.

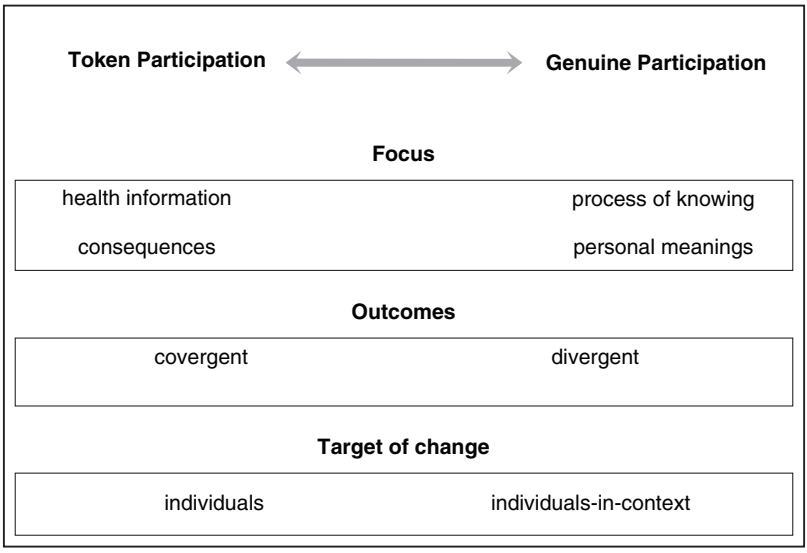

Figure 4.1 Three points of differentiation between token and genuine student participation

The first point of differentiation is the focus of the health-promoting and learning activities in which students participate. Two metaphors can be used to illuminate differences in the understanding of the process of learning in terms of the focus of participation: (a) individual acquisition of knowledge, and (b) participatory knowledge building. Token participation would have its focus on acquisition of curriculum content that has to be learned, accepted, and utilised. In the context of the health-promoting schools, such content involves the traditional factual knowledge relating to health and the hazardous effects of different behaviour 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 knowledge building through reflection on meanings and on different ways of constructing knowledge within the health domain. Factual information is addressed too, but it is the processes that lead to legitimation of information and its integration in a system of economic, historical, and ideological aspects that are considered essential. Students are involved in processes of knowing which are social and relational in their essence. These processes take place in communities of learners, consisting of both asymmetric relationships of students with teachers as more experienced dialogue partners and symmetric relationships with more or less equally skilled peers.

In contrast to the views of participation as merely a motivational tool, the experience from the 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, makes use of, and improves the potentials and possibilities of the environment. Thus, the challenge is to look at learning as a 'way of being in the social world, not coming to know about it' (Hanks, in Lave and Wenger 1991:24).

The second point of differentiation between token and genuine student participation is in the expected outcomes of the health-promoting school activities in which students are engaged. The outcomes of token participation could be defined as acceptance of pre-existing healthy lifestyles that correlate with facts describing what is healthy and what is not. The learning outcomes are closed or convergent: rules and facts regarding health are fixed, prescribed by experts on the basis of scientific evidence, without much room for personal choice and determination. Student participation within these frames means active practice in making 'healthy' decisions and developing assertive and other personal and social skills, in order to avoid health 'risks' and possible negative pressure by classmates, peers, or the media.

In terms of genuine participation, again the aims would be to encourage students' autonomy, their critical consciousness with regard to health matters, and their potential to deal with the complexities of their own lives and the world in active,

creative, and socially responsible ways. Consequently, the expected 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 existing in a particular school environment at a given moment. In other words, the expected outcomes of genuine participation would be the students' lived identities as active agents in health domains, based on negotiated, social, and imaginative learning experiences. The motivation and competence to engage in further learning also represents an important dimension of the expected outcomes.

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 with a view to changing their lifestyles, while within genuine participation the target would be individuals-in-context. In the latter, individual behaviour is closely intertwined with interpersonal involvements and organisational structures. In the words of Rogoff (1990:193):

> To act and communicate, individuals are constantly involved in exchanges that blend 'internal' and 'external' exchanges characterized by the sharing of meaning by individuals. The boundaries between people who are in communication are already permeated; it is impossible to say 'whose' an object of joint focus is, or 'whose' a collaborative idea is. An individual participating in shared problem solving or in communication is already involved in a process beyond the individual level.

As discussed earlier, the point of departure is that students' competences are not only their own property. The development of skills and competencies includes processes that occur at three levels – personal, interpersonal, and cultural. Students are as competent as their context (schools for instance) affords them the opportunity to be (Pianta 1999) and, at the same time, they are able to influence these circumstances and to initiate positive change. Therefore, it could be argued that if students have opportunities to participate actively in improving their surroundings as part of their education and thus be agents of their own learning, they are enabled to assume responsibilities for their own lives, to deal with change, and also to participate competently in the social web.

Arguably, health-promoting schools that are based on genuine participation hold the potential to achieve a better balance between the long-debated individualistic and structural (social) approaches to health promotion in schools (Simovska 2000). Health and health promotion are seen holistically without neglecting either the environment and health conditions or the individual and the importance of personal meanings. In the spirit of Vygotsky (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 with real people. Consequently, indicators for successful learning about health would not be only what a student knows, but rather what she or he wants to and can do alone or in collaboration with others.

Inherent to the conceptualisation of teaching and learning through genuine participation are issues of power and ownership. Genuine student participation allows for more room for student ownership of the learning process. Ownership presupposes that the potential for effective individual and group action is embedded

in the knowledge that is acquired. In contrast to traditional school knowledge, 'owned knowledge' positions its possessor as an acting subject, able to employ his or her knowledge in a dynamic way (Paechter 2001) by visualising different alternatives and dealing with complexities of change.

4.4 Case Study: 'Young Minds' Learning Through Participation and Action

The case study draws on the educational development project 'Young Minds – exploring links between youth, culture and health'. Young Minds is an international web-based project in which students from a number of schools in different European countries collaborate on issues related to health. The project as a whole has been organised in different rounds or phases, with students from different countries and schools taking part in each phase. Even though each project phase has a different content focus, they all follow the same overall educational design (for more about the project, see Simovska and Jensen 2003; Simovska 2005; Jensen *et al*. 2005).

The overall stated purpose of the project is to generate new, action–research-based knowledge on effective methods for engaging primary and early secondary school students in learning about health in an action- and collaboration-focused way. Democratic teaching and learning processes allowing for an adequate and flexible level of student participation shape the educational framework of the project. Further, the educational framework is characterised by action-focused teaching and use of information and communication technology (ICT) as an interactive platform for cross-cultural communication and collaboration. The web site, www.youngminds.net, created and administrated jointly by the students in all the participating classes, provided the main mediational tool defining the project's shared context.

An additional important feature of the project is the collective 'real life' action outside of the school frames, at international conferences with a high political and professional profile. This action was planned as part of the project from the outset; it was construed as a special kind of student action contributing to the project's main aims. In accordance with the conceptualisation of action suggested by Jensen and Schnack (1994), the action at the conferences as well as the actions taken as part of the classroom work were characterised by: (a) intentional mutual efforts of the participants, and (b) directedness towards initiating positive changes or making a difference with regard to the health problems in question.

The present case study is limited to: (a) the first project phase as a whole (YM1), and (b) the project work of a few selected classes from the second project phase (YM2). Table 4.1 summarises the main aspects of the two project phases constituting the case, that is, the duration, the overall topic, the participants, and the related conference.

Data were generated through document and web content analysis, observation and interviews with the participating teachers and students. The material used in this chapter forms part of a larger body of data collected for a doctoral research

Table 4.1 The boundaries of the case: duration, focus, participants, and related conference

	Duration	Overall topic	Participants (students, teachers, facilitators)	Related conference ('real life' action)
Young Minds 1	June 2000–January 2001	Youth, culture, and alcohol consumption	Approximately 100 students in four classes from schools in Denmark, the Czech Republic, Macedonia, and Sweden; their wrespective teachers and a facilitator in each of the countries	WHO ministerial conference *Young People and Alcohol* 19–21 February 2001, Stockholm, Sweden
Young Minds 2	February–September 2002	Well-being and the school environment	Approximately 100 students in four classes from schools in Iceland, Macedonia, Portugal, and Slovenia; their respective teachers and one facilitator for the whole group	ENHPS conference *Education and Health in Partnership*, 25–27 September 2003, Egmond, the Netherlands

project (Simovska 2005). In what follows I discuss the findings from the web content analysis concerning the participation structures that the students were engaged in over the course of the project, and the focus of their delineations of the contents, particularly in terms of health problems that student identified in their work, ideas for solutions of these problems, and actions taken with an aim to initiate positive change.

Peer collaboration and forms of interaction

The analysis of the web site content showed that in their work with the health topics, students were engaged in diverse types of inquiry activities, gathering information about the health issues at hand from a number of sources, including: surveys and questionnaires; experts', teachers', and other adults' opinions; literature and the Internet; and peer-generated information. The open-ended inquiry activities in which students were engaged assumed different participant structures and a plethora of forms of peer collaboration that were non-hierarchical, that is, mutual. As shown in Table 4.2, the range of classroom as well as cross-class activities was broad, resulting in diverse structures of interaction. The interaction structures were

common for the two Young Minds phases and involved the full range of possibilities: (a) small group work, (b) working in pairs, (c) whole-class discussions, and (d) individual work. The analysis showed that in both the project phases most of the

Table 4.2 Enquiry methods, participation structures, and forms of collaboration

Inquiry methods	Participant structures	Forms of peer collaboration
Cross-cultural surveys and questionnaires	Small groups, whole class	Negotiating and formulating areas of enquiry and questions to be used; administrating questionnaires; summing up findings; negotiating modes of graphical presentations of the findings on the web site; sharing reflections and comments on the findings; formulating conclusions and recommendations
School-based surveys and questionnaires	Small groups, whole class	
Surveys and questionnaires in the local community	Small groups, pairs, whole class	
Interviews with peers and teachers at school	Individual, small groups	Negotiating content and focus; formulating questions; conducting interviews; transcribing; formulating comments and reflections
Interviews with key people (politicians, policymakers, health professionals) in the local community	Individual, pairs	Negotiating content and focus, developing strategies to approach the informants; getting help from teachers, parents, and other adults; conducting the interviews, presenting and commenting joint comments
Photo narratives	Individual, small groups	Selecting places and objects, taking photos, selecting and putting photos on the web site, formulating the narrative
Mapping out the school and local environment	Whole class	Brainstorming ideas, suggestions, division of the work in small teams, negotiating teams and subtopics; selecting methods
Essays	Individual	Getting feedback from others
Web and literature search and review	Individual, whole class	Debate in the class, feedback, negotiating how to present the contents on the web site
Creative workshops involving drawing, modelling	Whole class	Modelling, drawing together, providing feedback mutually
Brainstorms and focused class debates	Whole class, individual	Mutual feedback, support, and criticism, complementing and confronting each other's ideas
Cross-cultural debates in the Forum and over email	Individual, pairs, groups	Exchanging ideas, comments, providing feedback

investigative work was done in small groups and pairs, and substantial time was devoted to whole-class discussions.

As shown in the table, there were two major forms of peer collaboration in these activity structures, focused on: (a) creating common frames of reference and shared focus, and (b) acting together to generate data for investigations or to prepare content for the web site.

This in fact meant that a variety of learning situations were created for the students to be engaged in joint productive activities[1]: *joint* for the reason that almost all the tasks that students had – in conducting inquiries and presenting them in a way that they could be communicated with the other students in the project – required goal-oriented student collaboration; *productive* because the investigative activities were aimed at producing specific joint products, i.e. material representations of their work with the project topic to be presented on the web site and discussed across classes.

Obviously, the individual inquiries were also embedded within these joint productive activities. Moreover, the teacher guidance and assistance were invaluable if the mutual interactions were to create shared discourse among the students, conducive to intersubjectivity. The common goals that students had in these dynamic forms of interaction helped create learning situations in which all of the participating students were in a position to both receive and provide assistance to others in certain aspects of the task, depending on their interests, skills, and preferences.

Furthermore, through cross-class collaboration on the Internet, the communication and mutual feedback students provided for one another cross-culturally widened the amount of interaction and assisted available performance in the classroom exponentially. Peers, both within the class and across classes, were seen as significant resources for learning, in addition to teachers. The inquiries made over the course of the project in all the classes, for example, the cross-cultural surveys and questionnaires, required mutual coordination and joint work. As students communicated about their activities and re-presented their findings and reflections for the benefit of their peers in the other classes, there were more opportunities for self-discovery of the tasks in which they were involved, and appropriation of their actions.

Health problems, solution ideas, and actions to bring about change

Given the fact that the action orientation was an integral part of the educational approach employed in the project, in the course of ongoing project activities the students identified a number of determinants of health problems and suggested various ideas for their solution. Table 4.3 summarises the causes of health problems

[1] The use of the term 'joint productive activity' is inspired by Dalton and Tharp (2002:183).

Table 4.3 Problems and possible solutions described by students

	Health problems and their causes	Ideas of solutions
Young Minds 1	Social pressure, norms of youth culture, traditions related to drinking;	Raising awareness among young people;
Alcohol consumption and young people	Family relationships;	Creating new, innovative structures for having fun without alcohol;
	Social conditions (opportunities, the 'feeling of society' legislative, traditions, advertising, access);	Improving family relationships; better understanding between parents and students; greater dialogue;
	Individual conditions (self-confidence, self-esteem, identity, coping skills, need to be independent, different, to belong, to connect, to prove oneself)	Involving governments, local authorities and school management to listen more to students' voices, involving students in decision-making process;
		Improving the psychosocial and physical school environment to foster personal development;
		Improving individual awareness, behaviour and lifestyle
Young Minds 2	Relationships at the school (both between students and teachers and among students);	More dialogue to foster trust, connectedness, belonging;
Well-being and the school environment	School architecture (uncomfortable classrooms, lack of space, lack of places for socialising and creative activities, inappropriate temperature, etc.);	Improving teachers' listening and communication skills;
	Stress related to schoolwork (assessment, exams, relationships);	Reducing learning-related tensions in classroom by using interactive teaching, teamwork, project work, open discussions;
	Inappropriate decision-making mechanisms at school (lack of student participation, inappropriate punishment strategies)	Improving the school building to address identified problems (involving other institutions such as city authorities, department of education, etc.;
		Reducing examination stress, improving relationships between students and teachers;
		Enhancing student participation in decision-making processes at school and in general in everyday school life;
		Organising more social events in the school;
		Motivating innovation

linked to the two overall project topics and ideas for solving these problems, which the students in YM1 and YM2 articulated and discussed on the web site.

As shown in Table 4.3, in relation to the issue of alcohol consumption and young people, the students participating in YM1 discussed related living conditions as well as lifestyles and personal determinants. The students reflected on, negotiated, and mapped out the variety and complexity of alcohol-related problems as well as their root causes. The scope of issues addressed by the students in their discussions included: (a) personal factors such as self-esteem, self-confidence, and identity issues, (b) concerns linked with the 'youth culture' – a sense of belonging, connectedness, and peer pressure, and (c) family circumstances, structural determinants, and the overall quality of life in society.

The students working with the issue of well-being and the school environment (YM2) almost exclusively discussed the social determinants of health-related problems. They pointed to four – in their view – very important categories of root causes relating to well-being: (a) the social relationships in school, (b) the physical (built) school environment, (c) the 'culture' of the schoolwork (i.e. examinations, assessment, etc.), and (d) democracy (i.e. student involvement) in everyday school life.

Furthermore, as shown in Table 4.3, in both the phases of the project the students did not simply identify problems or discuss their determinants in the manner of a scholastic, intellectual exercise. On the contrary, the participation and action orientation of the project framework, emphasising the four-dimensional knowledge model suggested within the democratic health education paradigm (Jensen 2000, 2004), provided stimulating space for the students to envisage different alternatives, including solution-focused ideas and areas of the students' potential impact. Consequently, the ideas that students developed about alternatives addressed root causes rather than merely symptoms of the problems: the solutions were seen in relation to determinants of the problems and both direct and indirect improvements were suggested in these areas. In both the Young Minds phases, improvements considered beneficial embraced psychosocial as well as physical living conditions and emphasised the value of active participation of young people in decision-making in this regard. In relation to the issue of alcohol, the students suggested a few additional strategies to approach some of the alcohol-related problems, including awareness raising and individual empowerment.

Table 4.4 summarises the variety of actions documented on the web site, which the students in the different classes planned jointly and carried out 'locally' in their schools or local communities as a part of the project. The table also demonstrates the specific changes they expected as outcomes of these actions.

Examples of actions, as shown in Table 4.4, include a change in school policy (a ban on school-based alcohol advertising), establishing new spaces in the school for students to socialise, and new, more inclusive mechanisms for decision-making at the school, amongst other things.

Evidently, in their work with health-related problems, students in both phases of the project were encouraged to consider the links between lifestyles, living conditions, culture, and context. More importantly, they were guided by their teachers to consider these in meaningful and purposeful ways, by reflecting on their own possible roles

Table 4.4 Examples of actions and expected changes

	Actions	Expected changes
Young Minds 1	Organising alcohol-free party at school	Raised awareness of young people; school-based parties as a good example
	Debate on alcohol between parents and students organised at school	Improved mutual understanding between parents and students; young people's voices heard; new structures at school for sharing ideas between students, teachers, and parents
	Suggesting (to the school management) changes to school policy on advertisements in school	A ban on using free drinks in school-based advertising of junior parties; alcohol-ad-free school
	Conducting interviews with the local mayor and the minister of health suggesting ideas for new policies and laws	Improved dialogue between the school and local community, voices of the young people heard by local authorities
Young Minds 2	Student led 'communication workshops' for all students in the school, teachers participate too	Improved communication among students and between students and teachers; better conflict management; improved social climate at school
	Suggesting (to the school management) specific changes in the school architecture, collaboration with an architect	Improved school building; more places for socialising; more flexible and student-friendly school environment; improved general feeling of the school, the school physical environment
	Suggesting (to the school management) improvements in the decision-making mechanisms in the school, e.g. establishment of a student council	Improved student participation in everyday school life; improved school ethos and democracy
	Presentation of Young Minds in the school	Raised awareness in the school community about the benefits of student active involvement and international collaboration; students and teachers encouraged to take similar initiatives; dissemination of the project principles and outcomes
	Presentation of Young Minds in the local media	Raised awareness; dissemination and lobbying; inspiration for other teachers and schools

and areas of influence, and by taking concrete action to bring about health-promoting changes. The forms of representation of the content used over the course of the project served not only to articulate information, ideas and concepts in the health domain with an aim to publish them on the web site, but also to help students learn how to use these representational systems in meaning-making, communicating, sharing, and discussing their understandings of the issues and arguments in the health domain.

Summing up

The analysis of the case study illuminates the trajectories of participation in which students learned about health in intentional, relational, and purposeful ways. These participation trajectories are viewed as situated in activity structures consisting of a variety of mutual interactions and different forms of participation, emphasising:

- Dialogue, i.e. suggesting, exploring alternative ideas, explanations, and problem solutions
- Action, i.e. envisioning and producing the most satisfactory outcomes possible at the given time in a given community of learners

In other words, students were engaged in a variety of processes of knowing, that included exploring, and envisaging solutions to the problems, and acting to bring about positive changes with regard to health. The classroom discourse and cross-class communication consisted of what Lave and Wenger (1991) call 'situated negotiation and re-negotiation' of ideas, concepts, meanings, and solution strategies as a basis for creating a common focus and frame of reference.

The students were involved in decision-making processes relating to both the process and the content of learning about health. The main areas of decision-making in which the students took active part included:

- Selecting relevant aspects/issues relating to the overall topic
- Deciding on the variety of questions to be researched
- Negotiating the methods of investigation and different modes of representing the findings
- Creating peer teams in which to work and organising the work within the teams
- Deciding about the representation of the content on the web site
- Selecting and planning specific actions to be taken to bring about positive change

Table 4.5 gives a summary using the participation model discussed earlier. It shows how the aims and expected outcomes of the student participation in teaching and learning activities over the course of the project were open and divergent, and that they depend on the choices that students made, together with their teachers, during the teaching and learning process.

The case study also shows that the participatory and action-oriented teaching approach, as employed in the project, can extend beyond the traditional focus on the subject matter prescribed by the curriculum. There was no pre-formulated, fixed content, or body of knowledge in the health domain that the students had to learn, memorise, recall, and employ. Even though the overall project topics were decided outside the project's frames and were assigned to students, the students investigated the area in their own ways, guided by their teachers and using the broad possibilities of ICT and cross-cultural collaboration.

The analysis also reflects the fact that the focus of the participation was on processes of critical reflection, goal-oriented dialogue, and negotiation of meanings related to health matters, rather than on moulding students' health-related behaviour and lifestyles.

Table 4.5 Characteristics of student participation in Young Minds

Student participation was *focused* on	Investigation in the broad area of the project's overall health topics, creating shared frames of reference, developing common understandings, exploring alternative ideas, explanations and problem solutions, and creating visions across classes (i.e. cultures) to construct problem solutions
The expected *outcomes* concerned	Planning and taking action together with others, bringing about changes as a part of learning, students' enhanced awareness about local and global aspects of health problems, critical thinking, creative articulation of ideas, responsible collaboration, sense of the other
Students' actions *targeted*	Everyday school life, policies and decision-making mechanisms at a whole-school level, policies in the local community, links between school and the local community, awareness of teachers, parents and policymakers about young people's voices concerning project's topics

Furthermore, the fact that the students shared the responsibility for selecting those aspects of the topics to be investigated and the methods they would use to do so resulted in an increased sense of ownership of their learning activities. This led further to increased student intent and responsibility and to the development of new strategies for mutual collaboration, which contributed to successful completion of the learning tasks at hand, and, arguably, to building knowledge as well as competence to take action.

The collaborative knowledge-building activities in which students were engaged in Young Minds were action focused. This involved working with a more comprehensive and complex landscape of knowledge encompassing insights into causes rather than only consequences of health problems, as well as visions about the future, and knowledge about solution strategies (Jensen 2000, 2004). This knowledge was of interdisciplinary character and built in a shared process of critical dialogue, reflection, development of shared visions, and taking joint actions. Consequently, the health issues that students explored, articulated, and represented on the web site evidently belonged to the democratic rather than to the moralistic health education/promotion discourse. Evidently, the students worked with an open health concept, addressing the social determinants of health and suggesting structural as well as individual solutions for selected health problems.

All these point to a genuine participation discourse whereby the participatory teaching and learning (as opposed to a transmission teaching model) was clearly directed towards facilitating, encouraging, and extending the educational dialogue about health issues that were of relevance to the community of learners. Learning was situated in students' everyday lives and experiences. Moreover, it made use of a variety of cultural resources, local community knowledge, and more global cross-cultural norms, differences, similarities, and traditions.

The student involvement aimed primarily at their socialisation to the democratic processes of making decisions, creating meanings and visions together with others, and acting to reach shared goals, but also at knowledge building as well as development of social, emotional, and personal competences with respect to health. In this sense, the content of the curriculum served the role of a 'mediating resource' (Wells 2002; Wells and Claxton 2002) for shaping the processes of learning by participating in 'communities of practice' (Lave and Wenger 1991), rather than being an end in itself. As a result, opportunities were provided for creating dynamic and overlapping collective 'Zones of Proximal Development', where students moved in and out as they appropriated – that is, transformed as well as internalised – health-related cultural resources – knowledge, competences, skills, and strategies for change – and practices.

Within these learning zones the students' individual choices were interdependent: they constituted one another and also depended on the possibilities that existed at the level of the group or the community of learners. The community of learners was heterogeneous with regard to experience, competence, skills, and knowledge, which created a specific dynamic structure of the learning zones consisting of more as well as less experienced participants, complementing one another's learning. In other words, within these collective zones of proximal development, meaning and knowledge were co-constructed within a cooperative environment that included various forms of social interaction and interpersonal (both asymmetric and symmetric) relationships. The processes of collaborative production allowed for the processes of collective learning to take place, leading gradually to the establishment of common frames of reference and a common foundation for knowledge building. One of the crucial aspects in this regard was externalisation or objectification of jointly created ideas and meanings about health into products or 'works' (Bruner 1996). Representation of one's thoughts, understandings and still-to-be-formulated ideas as part of teaching and learning process, as well as their communication with others through discussion, sharing, and receiving reactions from others in a critical but collaborative spirit, fosters learning at both individual and group level.

In these ways, it is argued, teaching and learning about health by participating in democratic learning communities can serve as a primary means of initiating students into an appropriation of the values, beliefs, ways of knowing, and rituals of the health education/promotion discipline, which, ultimately, can also be conducive to the development of their action competence or their potential to participate in creative, critical, and responsible ways in health matters that concern them.

4.5 Future Challenges

Although 'Young Minds' could be seen as an exemplary case of involving young people in learning about health within the health-promoting schools initiative, there are a number of challenges to be addressed if the principles of genuine participation and the action-focused teaching and learning strategies are to become embedded in

the everyday praxis of the health-promoting schools, rather than representing an isolated example of 'good practice'. Given the various theoretical considerations, insights and reflections, empirical findings, and strengths and limitations of the study, the dilemmas and challenges for further research arising from the study include:

- What parallels can be drawn between the project-based teaching and learning about health as documented in the present case study and regular health education and health promotion in schools? What, for example, are the possibilities for and barriers to creating diverse classroom structures and mutual interactions that encourage intersubjectivity and participation in meaning? In other words, how can transferring the project-based principles of classroom organisation and cross-cultural collaboration into regular health education and the health-promoting schools curriculum be supported, which would allow for genuine student participation and which would seriously take into account students' as well as their community's concepts, ideas, concerns, and everyday experience in relation to health?
- What is the adequate and efficient balance between different participation structures in classroom teaching and learning processes (in terms of teamwork, individual work, work in pairs, whole class discussions, direct instruction, etc.) if the aim is to utilise the benefits of peer collaboration and design teaching and learning situations that are in advance of students' current developmental level? In this respect, what is the role and impact of voluntary non-participation on students' learning and competence development?
- In the context of school health education, what is the realistic and beneficial interplay between dialogue and taking 'real life' action to initiate positive change with regard to health, given the typical curriculum workload, the number and diversity of students in a class, and the existing tensions between standardised learning outcome requirements on the one hand, and participatory teaching approaches on the other?
- What constitute adequate teacher competences for guiding teaching and learning processes and fostering learning and the development of action competence within democratic communities of learners composed of dynamic zone(s) of proximal development? What forms and strategies of professional development and teacher support can more efficiently help teachers shape their professional identities as facilitators, consultants, and moderators of the processes of knowing, that is, as knowledge makers rather than transmitters? With this regard, what is the role and value of supporting mutual collaboration, relationships, and social networks among teachers, on different levels – school, national, international?

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