Implementing the European Network of Health Promoting Schools in Bulgaria, the Czech Republic, Lithuania and Poland: vision and reality

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SUMMARY
This article explores key developments in health promotion within the European Network for Health Promoting Schools project (ENHPS) in four formerly communist countries: Poland, the Czech Republic, Bulgaria and Lithuania. The concept of the Health Promoting School has been uniquely interpreted by these countries resulting in a variety of health promotion initiatives at school, community and national levels. These include: variations in the management of the project in the different countries; the direction and support for schools provided by the national project teams in each country; the effect of national governments on project outcomes; the communication between project participants and strategies for disseminating project outcomes; the training of teachers and health professionals; and the extent to which the local community and parents have been involved in school projects. The introduction of a holistic concept of health promotion into the education system and schools in these countries has inspired and equipped teachers to adopt 'democratic' approaches to health education teaching and move away from the more traditional, didactic approaches. The two researchers witnessed more relaxed relationships and more opportunities for pupils to engage and be active. This corresponded with changes in the political, social and economic conditions of these countries since the removal of communist regimes. The vestiges of past regimes, current economic circumstances and national histories inevitably play a part in the context in which a radical vision of ENHPS is embraced by entrepreneurial professionals in under-resourced communities and schools.

Key words: active learning; eastern Europe; educational innovation; Health Promoting Schools; WHO

INTRODUCTION
The principal aim of the European Network for Health Promoting Schools Project (ENHPS) is the establishment of a network throughout Europe which will provide a framework for innovations in health promotion and a basis for the dissemination of models of good practice. The pilot ENHPS projects began in 1991 in four countries. By the end of 1997, 37 countries were involved. The ENHPS is managed by the Technical Secretariat of the World Health Organization’s (WHO) Regional Office for Europe, and overseen by the International Planning Committee which has representation from WHO, the Council of Europe (CE) and the Commission of the European Community (EC), the three organisations providing funding for the project. Participating countries also acquire supplementary funding from internal sources and non-governmental organisations.

Health promotion in schools, as an educational innovation, is explored through a review of the ENHPS in four formerly communist countries:
Poland, the Czech Republic, Bulgaria and Lithuania. These countries were selected for study because they were four of the first to become involved in the project. In addition, there was the challenge of identifying how a particular concept of the Health Promoting School was being introduced into an eastern European context. The characteristics of each country shaped the implementation of the ENHPS and resulted in a variety of initiatives. These characteristics include: the management of the project; the organisation of national governments; the relationships schools form with their communities; and the degree of professional involvement by teaching and non-teaching staff, health professionals and the national project team in the schools.

This report is based on the analysis of documentary evidence available in the WHO Copenhagen offices and interviews conducted with key informants in the four countries. The documentary evidence comprised 6-monthly project reports from the ENHPS national teams, information from the WHO Regional Office on the national projects and material acquired during the visits. Interviews were conducted with WHO officials in Copenhagen (two), the national project coordinators, members of the national teams and health professionals (ten). Visits were made to selected health promoting schools to interview school project co-ordinators and school teams (22 teachers, usually in groups) to explore the perspective of project participants.

An interview schedule was used to guide the gathering of data on the essential features of the project in each country. Provision was made to investigate the ‘meaning’ of health promotion national projects in schools and to identify unique features of its implementation in each country. Dissemination of ENHPS within the countries was also addressed. The fieldwork was carried out in June/July 1995. The analysis is set within the political and economic broader context and history of these four countries collectively as they emerge from communist principles of command in the economy and in social welfare.

THE ‘SETTINGS APPROACH’ TO HEALTH PROMOTION

Historically, schools in most countries have included some form of health teaching. However, it is only during the last 15 years that planned approaches to developing comprehensive programmes for health education have occurred. The stimuli for development varied over time (Lewis, 1993) and between countries (Williams and Woester de Panafieu, 1985). Tones and Tilford (1994) note the significant role played by the WHO in promoting schools as settings for health promotion.

In 1990, at the ‘Education for All’ conference in Thailand, the WHO presented a world-wide review of the status of school health education. It emphasised the importance of health education for all children and outlined issues for action. The agenda for action included: the need for schools to become health promoting institutions; health education to be planned in the context of pupils’ families and the wider community; and the training of teachers to promote health (WHO, 1990). The 1991 Geneva Consultation Conference concluded that schools and communities should be partners in health promotion (WHO/UNESCO/UNICEF, 1992). The success of the WHO-sponsored Healthy Cities Project provided impetus for health promotion developments in over 300 cities (Fryer, 1988; Kickbusch, 1989). These developments gave credibility to the ‘settings approach’ to health promotion and led to the initiation of the ENHPS Pilot Project in 1991 and the phased introduction of the project into other countries. A settings approach to health promotion emphasises the importance of the creation of healthy environments. This differs in important ways from the health behaviour approach, which focuses on promoting individual health behavioural change. It was interesting to discover the extent to which the settings approach to health promotion had been adopted in each country, whether it had been confined to the classroom or whether it had been extended across the school and into the community.

MEETING THE CHALLENGES OF ENHPS IN THE COUNTRIES OF CENTRAL AND EASTERN EUROPE AND THE NEWLY INDEPENDENT STATES

The WHO (EURO) (1993) conception of a Health Promoting School embodies a holistic approach to health promotion, accepting that individual, societal and environmental factors influence health. Parsons et al. (1996) present a
full analysis of the origins, management and criteria of ENHPS. For schools to operate as effective health promoting institutions, collaboration between staff, open communication and teamwork are necessary. In the Countries of Central and Eastern Europe (CCEE) and Newly Independent States (NIS), the creation of a collaborative culture with teachers, health professionals and parents working together to promote the health of pupils was a novel experience and significant achievement.

To appreciate the seductiveness of, and barriers to, the implementation of ENHPS ideas, one needs some comprehension of the broader contexts, in all their variety, of CCEE and NIS. Communist regimes were unambiguously committed to collective provision in a command welfare economy. Health, housing, education and social services were centrally planned and allocated. Individualism and entrepreneurialism are now given scope, albeit within bureaucracies which appear to retain a surveillance role. Interesting tensions exist for the educational innovators who, in local and national environments of control, are none the less valued for their links with western European ideas and resources. The trend in countries in the West is towards more government involvement in welfare, because of known market imperfections, while, in contrast, eastern Europe introduces market forces to deal with the failure of excessive government involvement.

Those exporting innovations to less wealthy countries must acknowledge economic realities. Ringen (1994, p. 9) reports how revolutions are costly for the people exposed to them, and in the countries emerging from communism the population is living with real incomes falling, savings depleted, and rising trends in poverty, unemployment and overcrowding as the provision of new housing slows. As Nutbeam and Wise (1996, p. 221) state, despite generally increasing life expectancy, data now emerging from the former socialist countries of Europe indicate that progress may not have been as substantial as anticipated and inequalities between countries have not generally declined.

These inequalities are realities which colour relationships and expectations in eastern European countries piloting ENHPS. Material support and progress are urgently sought by these countries and this must, by comparison, implicitly diminish the radical, empowering vision of ENHPS which constitutes a less obvious and tangible set of processes and goals.

The countries visited, however, had in common mature educational systems of the sort described by Laporte and Schweitzer (1994), 'with a rich, scholarly tradition which predates communism'. Therein lies a significant barrier to ENHPS principles and practice. More telling still as a barrier is the absence, until recently, of a 'third sector' of non-profit-making and voluntary organisations. These are being developed, and at national and international levels they are being energetically pursued for cash and support. Laczko (1994) warns of the dangers of the lack of co-ordination between organisations in the 'third sector' and between these and governments. At the international level he expresses concern at governments in the West sponsoring the third sector in Central and Eastern Europe with money and technical support 'without much knowledge of the characteristics of the emerging voluntary non-profit sector and how it operates' (Laczko, 1994, p. 97).

In the midst of these changes there is an increasing array of attractive opportunities at the local level, but diminished capacity to take advantage of them. One of the features of the current situation which Deacon (1992, p. 170) identifies, in relation to social policy developments, is an increase of local community control over local social provision, but with fewer resources from the state. Local communities have not yet established their own tax base.

The bulk of this paper examines the reaction to and adoption of ENHPS in the four countries. It reports and analyses the illustrative data under the following headings: 'Active learning'; 'National governments and ENHPS'; 'The role of national ENHPS teams'; 'The training of teachers'; 'The management of change within schools'; and 'Strategies for the dissemination of good practice in health promotion'.

ACTIVE LEARNING

'Active learning' has become part of the discourse of health promotion. As an umbrella term, it draws on the writings on Bruner, Gagne, Kolb and also Vygotsky and is best understood as 'active' in the sense of being about personal adaptation and critical engagement (Beswick, 1987). It is articulated in its most developed form probably in Denmark with the notion of
‘action competence’ (Jensen, 1995). Its export to formerly communist countries and its acceptance at the theoretical or practical levels is a matter of considerable interest.

A member of the Czech Republic team explained that ‘active’ learning approaches were not part of the culture of the schools under communism. Typical examples of active learning approaches now encouraged were activities where pupils worked together on projects, shared and discussed books, and where children engaged in activities which required communication, problem-solving and decision-making. Stimulus for this new way of working came from example activities included in the (Scottish) training manual Promoting the Health of Young People in Europe: Health Education in Schools (HEBS, 1993).

One member of the Czech national team, who was a member of a national pressure group promoting active learning, was inspired by the thinking of an American author, Susan Kovalik (1993), who wrote Integrated Thematic Instruction. Kovalik (1993) analysed traditional teaching approaches and formulated eight compatible elements of learning. For example, for learning to take place, the learning experience should be meaningful to children and they should learn in the absence of threat. One member of the national team said:

The current education system is harmful to children’s development. An oppressive system developed in the 1800s, which can be likened to a totalitarian regime. Separate subjects were taught and knowledge was transmitted to children in a highly disciplined manner.

Another team member believed that the teaching methods used in the Czech Republic reduce pupils to partial or total failure and that they are unable to reach their potential. . . . Children need security, love, understanding and respect if they are to develop. There is a need for a change in pupil–teacher interaction and teachers need to have permission to make use of their creativity, imagination and initiative to develop positive attitudes amongst pupils. A radical change in the atmosphere of schools is essential. Teachers also need to obtain feedback from the pupils and teach them about self assessment.

A central aim of the national project was to create an atmosphere more conducive to learning, where ‘the teachers would encourage the children to share their concerns with them and work in partnership with the children to address these’. Teachers were not trained in these pedagogical methods. The national curricula in the Czech Republic and in Bulgaria continue to require largely didactic teaching approaches. However, in other eastern European countries, teachers are beginning to implement active teaching methods to improve pupils’ decision-making responsibilities, and enhance relationships amongst members of the school community.

ENHPS encourages methods which include problem-solving, investigations, group discussions and development of collaborative projects. This initiative has had varied impact in the different countries. In the Czech Republic, schools received a translation of the HEBS (1993) publication, and a cascade model of training in active learning techniques was adopted. Two workshops were held nationally to train 70 teachers in the use of these materials, in order that they might run seminars within their own regions. In Lithuania, all schools received the translated manual, and the teacher training institution introduced head teachers, school co-ordinators and teachers to active learning methods. In contrast, the national team in Bulgaria felt that the manual had limited use, believing teachers needed examples of practical activities.

National co-ordinators often produce written information to disseminate good practice in health promotion. For example, in the Czech Republic a national newsletter, Ratolest, published four times a year, reports on examples of work in progress, including the use of active teaching methods. Schools in the Czech Republic also prepare and circulate newsletters between each other to share ideas and experiences, although these have been spasmodic due to production expenses. All schools in Poland receive a monthly magazine containing accounts of experiences and materials from project schools.

NATIONAL GOVERNMENTS AND ENHPS

There was a variation between countries in the extent to which government objectives for health promotion influenced the direction of projects. In all four countries the existence of a national curriculum affected the progress of the project. There was variation in the prescriptiveness of the national curriculum and a key factor was the extent to which schools had discretion in its delivery. Furthermore, the tendency for the project to come under the Ministry of Health in each
country reduced the Ministry of Education commitment to ENHPS.

In Lithuania, the national curriculum governed health promotion priorities and strongly influenced the implementation of school projects. Four main issues identified at a national level—interpersonal relations, nutrition, physical exercise and environmental health—had to be included, and health education had to be integrated into other curriculum subjects. However, schools were able to devise their own health promotion plans within this context. For example, one urban school devised a programme to enhance pupils’ participation in physical activity by increasing the number of physical education lessons in the curriculum. In addition, teachers arranged visits to parks and forests for pupils to get fresh air and take exercise. In comparison, a rural school’s activities centred on environmental protection education and building up positive relationships between staff, parents, pupils and the community.

Education legislation in Bulgaria and the Czech Republic has restricted schools’ flexibility to organise health education within the curriculum and select appropriate teaching methods. The knowledge, skills, teaching styles and assessment procedures are prescribed. The active, child-centred pedagogy promoted by ENHPS is contrary to that required by national legislation. However, in the Czech Republic the project participants circumvented these restrictions by developing health promotion outside the prescribed curriculum. The national team thus sought divergent responses that met school and community health needs.

School co-ordinators in Bulgaria and the Czech Republic pressurised national teams to lobby the Ministry of Education to give the project more status, and gain exemption from the law for health promoting activities. As a result, in the Czech Republic the Ministry of Education granted project schools permission to omit 30% of the curriculum without specifying which elements, and some freedom to decide the teaching approaches. In the future, the law will be altered to enable schools to experiment with new methods and organisation, under the control of the Ministry of Education.

There is a variation between countries in the relationship that exists between the Ministries of Health and Education. Project teams generally agree that if the two ministries co-operate in promoting the educational element, there is a greater chance of schools enhancing children’s health and securing staff commitment to the project. In Poland, co-operation between the Education and Health Ministries meant schools could experiment with new methods for promoting health. The Ministry of National Education became interested in the project because it enabled the promotion of new teaching methods in schools.

The Bulgarian Ministry of Education showed little interest in the project, as the national team was part of the Ministry of Health. Thus the information passed to the Ministry of Education was spasmodic. This made the planning of project events and future action uncertain, because these events required the Ministry’s consent.

THE ROLE OF NATIONAL ENHPS TEAMS

The composition of the national teams, in terms of professional interests and commitment, has influenced the development of projects in each country. The teams in Bulgaria and the Czech Republic, which have centrally controlled curriculum, wish to see a more ‘democratised’ education system and the use of active learning methods. They reported that existing didactic methods prevented pupils forming positive learning attitudes. It was explained that active methods would enhance pupils’ motivation, self-esteem, confidence and ability to make health decisions. There have been changes in the political, social and economic conditions of the countries since the removal of the communist regimes. These include democratisation, decentralisation of public sector organisations and the introduction of a market economy.

The Czech Republic national team consisted predominantly of educational psychologists, who were members of an educational pressure group promoting active teaching. They lobby the Education Ministry to permit experimentation with a variety of teaching methods. They recognise, however, that reform in the education system would be slow and entail a radical change in the culture of schooling. National co-ordinators report problems schools have in implementing the project to the Technical Secretariat.

In Bulgaria, apart from paying the national team their salaries, there was no additional state funding. This led to poor office facilities which hindered communication. The national team had
to pay for some of the training events for school co-ordinators themselves, in the hope that they would recover the costs later.

THE TRAINING OF TEACHERS

National project teams organised the training of teachers in the project schools. In Poland, the team provided 80 h of training for teachers in project schools. About 500 teachers, representing 67% of the participants, took part. The national team, in conjunction with Poznan University and the National Teachers Training Centre, presented three postgraduate courses on health promotion. In the Czech Republic and Bulgaria, the national teams built up teachers' confidence to experiment with the new teaching methods. The teams obtained information on health promotion and pedagogy from other countries and the WHO. A factor limiting training in Eastern Europe is the difficulty the national teams have raising funding for workshops. Furthermore, these teams found it difficult to identify people to advise on health promotion and run workshops.

National co-ordinators meeting at international events, such as conferences, have been able to share experiences and establish joint initiatives. This happened in Poland and the Slovak Republic. In 1994, school co-ordinators met to exchange experiences. A summer camp was then organised for members of the Slovak and Polish pupil parliaments. Within schools pupil parliaments provide the forum for pupil representatives to communicate their concerns and needs to staff. In 1994, the Technical Secretariat organised the international conference ‘Health Education and Democracy’ for researchers, teacher trainers and teachers in 30 countries, to explore strategies for establishing democratic processes within health education. These groups are working collectively by using a process of mediation to raise the project’s profile.

The Czech Republic team produced a video to illustrate the impact of training teachers in active learning techniques. Young children work in groups whilst painting, playing educational games, reading together and undertaking mathematics to develop communication skills. An example of co-operative, student-centred learning in secondary schools showed children working together on computers.

THE MANAGEMENT OF CHANGE WITHIN SCHOOLS

Collaboration and teamwork are essential if institutional change is to be effective. Through teamwork, individuals can share expertise and address the concerns of, and resolve conflict between, individuals or groups. The NIS national teams worked with school co-ordinators to motivate staff and create a positive attitude to change. In Bulgaria and the Czech Republic teachers were unfamiliar with collaborative working and this inhibited the development of a health promoting school ethos. Teachers requested overtime payment as a recognition of the extra time devoted to the project. In some schools, interest declined when this was refused.

In the NIS and CCEE under communism, outside professionals were involved in the life of schools, and a medical model of health promotion was used to promote health. Before 1985, teachers, from the project teams that were interviewed, believed that children’s health depended on the school doctors, who were often attached to schools to examine children and treat their health problems. In Bulgaria, for example, this conception was reflected in the teaching materials used with pupils. Pupils formerly received health education through centrally produced packages on a number of topics, such as personal hygiene, first aid, sex education and drug use (Ruiter, 1995). The Bulgarian national team encountered teachers who were suspicious of the project, seeing it as a means of turning pupils into ‘good communist people’ rather than healthy people. These teachers thought the government would end up repeating the failed experiments of the past. The team had to educate teachers about the value of the project and the holistic nature of health. After 1989, health education became neglected in schools because it was not compulsory. Consequently, the team argued for changes in the national curriculum to raise its status. Once the schools understood the project goals and the concept of the HPS, they were willing to participate. They discovered how staff could devise a plan to promote social interaction, teamwork and, as a part of a network of schools, learn new teaching methods to develop children’s self-esteem.

In an urban school visited in Bulgaria, the project team were fully aware of the effects that the physical and social environment had on the school community. The physical environment
was poor. Pupils had to share desk benches in overcrowded classrooms that were falling into a state of disrepair. Although the school had little money to improve the physical environment, the teachers painted animals on the walls to brighten up the environment of the classrooms for young children. The school worked on improving the social environment instead, by becoming a community centre where the children could come to play chess and table-tennis outside school hours and use the grounds for sport. There were virtually no sporting facilities available to the community. The teachers and school psychologist worked to try and improve teacher–pupil relationships so that children would share their problems with their teachers. The teachers established a team to share their concerns and teaching ideas. Children have had the opportunity to work together in groups on projects and even teach their peers to develop their pride and social skills. This was reported to be very popular. Changes in the organisation of staffing occurred to promote positive relationships. One teacher now teaches grades 1–4, whereas in the past different teachers taught the class.

There is a widespread recognition that the involvement of the school’s community and medical professionals could promote children’s health. In Lithuania, improving pupils’ nutrition and awareness of what constitutes a healthy diet was a national priority. A National Nutrition Centre advised schools on diet. It is producing a programme on nutrition for schools. The departments at the Institute of Physical Culture in Kaunas advised on physical activities. The Kaunas Medical Academy produced a smoking prevention programme for teachers, consisting of age-related teaching materials. Educational psychologists and school nurses attached to schools worked alongside teachers in promoting the pupils’ health.

In all the countries, schools sought to include parents in health promotion. In Bulgaria and the Czech Republic parental involvement was a major success. Under the communist regime, parents had little communication with schools. They were unwelcome in the schools. Some parents continued to be suspicious of schools, and regarded them as places for indoctrination. The schools are presently trying to build trusting relationships with parents. In one school in Bulgaria, the parents helped to raise the money for a camping trip for teachers and their pupils in the mountains. This broke new ground in home–school relations. Another school invited parents of the fourth and sixth grades into their schools to see how their children learnt. They worked with parents to manage behavioural problems. In one school in the Czech Republic, a headmistress tried to work with the whole village to promote pupils’ and parents’ health. The school provided activities for parents to participate in and involved them in celebrations. They were encouraged to visit the school each week to watch their children being taught and to find out about the new teaching methods and the positive relationships that were developing between teachers and pupils. Coffee facilities were provided so that parents could meet and talk with each other at ease.

**STRATEGIES FOR THE DISSEMINATION OF GOOD PRACTICE IN HEALTH PROMOTION**

The four countries studied illustrate some of the channels and barriers in the dissemination of new ideas. The development of the ENHPS depends on national teams devising strategies for disseminating health promotion practice, taking account of national features. In Bulgaria, the geographical location of project schools hindered meetings between school co-ordinators and schools working together on joint health initiatives. Project schools were selected from different administrative regions to take account of the cultural differences, and with a poor transport system, visits between schools were expensive and time consuming. Communication between schools was therefore mainly in a written form or at workshops.

To overcome the geographical difficulties, the Bulgarian national team created a structure to support all schools in the country wishing to engage in health promotion. This network includes schools that applied, but were not selected, for participation in the project. The project schools served as a model for the non-participating schools in their region. Later, a third network became established for schools wishing to work on particular health programmes, such as ‘healthy eating’ or ‘sex education’. These latter schools received information about the ENHPS, but otherwise did not communicate with the national team.

Although Poland has 14 schools in the national project, 29 out of the 49 districts have created
regional networks of health promoting schools. The national team organised a summer school and one meeting every year for school representatives to attend from the regional networks. In this way schools shared ideas for health promotion. Schools were sent materials and books by the national team to assist them with their work. In all the countries, activities increasingly became shared between schools. In the Czech Republic and Lithuania, for example, seminars took place in different schools two or three times a year to demonstrate health education lessons. In Poland, three national conferences were held for school co-ordinators and staff in the national project to share experiences. Factors limiting the effectiveness of these conferences included the numbers willing and able to attend from each school, the accessibility of the training school, and the opportunities provided for participants to brief their colleagues. In Eastern Europe, the concept of in-service training is not well known. Links have been formed between schools within each country. However, schools in different countries are beginning to work together on projects. For example, in 1995, some Polish teachers visited their counterparts in the Slovak Republic. Two schools in the Czech Republic twinned with a school in Denmark to undertake a 1-week project to develop ideas for ‘democratic health education’. This formed the basis for projects in the Czech schools. Teachers participated in all aspects of the project, facilitating staff exchanges between the two countries. The Danish Foreign Ministry funded the project. An increasing number of schools in western Europe use electronic mail to share ideas and exchange views about health matters. The database, constructed by the Technical Secretariat, of national co-ordinators and project members could further encourage twinning between schools internationally.

**CONCLUSION**

This small-scale investigation into the implementation of the ENHPS in four national settings emerging from communist rule, revealed a diverse range of health promoting initiatives. The vision of the health promoting school is explicitly documented by WHO and, as with any vision, there was a reality at national and school levels brought about by unique interpretations. National structures, communications, training, and the involvement of teachers and other professionals in school projects were key influences on the variation between the countries. Pilot schools implemented health promotion initiatives to meet institutional needs which were stimulated by a complex set of ideas of essentially western European origin, mediated through the vital agency of the national project team, but within constraints of regulations and resources set by national conditions. The particular demands of the national curriculum influenced the schools’ abilities to experiment with active learning techniques. In some countries the aims decided by the national team influenced the foci for school projects. The location of the project in the Ministry of Health affected the status that the Ministry of Education gave the project. Schools and national teams sometimes had to lobby the ministers to obtain permission to experiment with new teaching strategies. In what continues to be a fluid situation with entrepreneurial opportunities it is essential, if health promoting schools are to prosper and increase in number, that national teams continue to lobby the Ministries of Health and Education to obtain their sustained commitment to health promotion initiatives in schools.

In the CCEE and NIS the encouragement for professionals to take an entrepreneurial stance in state organisations has been muted in the past. Now there is the paradox of the entrepreneur and innovator valued, but functioning alongside the vestiges of old-style bureaucracies. There is the attraction of working with visionary new ideas from western Europe in national contexts where economies are in decline and social welfare under funded. There are the traditions, inside and outside education, to confront, and new institutional arrangements to be made with uncoordinated national and international NGOs.

At institutional level, the participation of outside professionals, parents and the community was a key element in supporting schools in pursuit of their health promoting goals. The commitment of staff to working as a team to encourage a health promoting ethos within the school was important. In some pilot schools in these regions, staff commitment was difficult to secure due to the extra work imposed on the teachers. The national co-ordinators were crucial in enhancing the motivation of staff in the project. The potential for involving a range of external agencies to provide information on health and practical teaching methods has yet to be fully explored.
It is vital that schools encourage parents and members of the local community to participate in the project and training events. The schools can work with parents to deal with pupils' problems, ask parents to raise money for training and teaching materials, and encourage parents to undertake health promotion activities at home. Parents and members of the community can also help to improve the school environment and lobby local officials for support. Such strategies may counter the lack of centrally provided funds referred to earlier.

The dissemination and support of active learning has been an intriguing success of the project. ENHPS seeks to maximise the quality of the process through which young people become empowered to make decisions about their health related behaviour (Ziglio, 1995). This conception goes beyond employing what Naidoo and Wills (1994) describe as medical and behavioural change approaches to health promotion. It encompasses the empowerment model (Tones and Tilford, 1994). In terms of Hagquist and Starrins’ (1997) typology of school health education, it is the most radical version which defines ENHPS, as promoted by the WHO, and as enthusiastically embraced by the national teams and the schools in the four countries.

Each of the countries visited experienced significant successes in grasping, adapting and implementing the vision of health promotion in the project schools, and, in some cases, in other schools. Once the project has become established in project schools, staff could collaborate with teachers from surrounding schools to help them establish health education within the curriculum and positive attitudes to health through the school community.

The health promoting school takes diverse forms. Comparing the situation in Denmark (Jensen, 1995), Australia (Colquhoun, 1997) and the developing countries (Child to Child Trust, 1997) confirms it as an elaborate set of ideas having great appeal on many levels. In the multi-faceted complexities that make up ENHPS as an innovation in a changing, unpredictable and sometimes recalcitrant world (Levin and Ziglio, 1996), the vision is vitally important. It appears to be sustained at all levels in the CCEE and NIS with street-level innovators, local support and national tolerance coupled with sometimes ambiguous backing, and continent-wide status and communication from the WHO.

Empowerment is with the pilot teachers and implementers of ENHPS. Outsiders to the national project, and to the national political scene generally, will have to be sensitive to the very difficult economic conditions of the CCEE and NIS and take advantage of the intellectual entrepreneurialism emerging in a situation depicted by Cox (1994, p. 234) as one where old elites are being displaced by new elites. There are intriguing possibilities to be monitored as ENHPS is disseminated more widely within the countries, extending active learning methodologies and requiring support form national governments, NGOs and local communities.

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