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an analysis of institutional rationales

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Title

Reconceiving barriers for democratic health education in Danish schools: an analysis of institutional rationales

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Abstract

Health promotion - and education researchers and practitioners advocate for more democratic approaches to school-based health education, including participatory teaching methods and the promotion of a broad and positive concept of health and health knowledge, including aspects of the German educational concept of *bildung*. Although Denmark, from where the data of this article are derived, has instituted policies for such approaches, their implementation in practice faces challenges. Adopting a symbolic interactionist analytical framework this paper explores and defines two powerful institutional rationales connected to formal and informal social processes and institutional purposes of schools, namely conservatism and Neoliberalism. It is empirically described and argued how these institutional rationales discourage teachers and students from including a broad and positive concept of health, the element of participation, and the promotion of general knowledge as legitimate elements in health education. This paper thus contains a perspective on health education practice, which, in a new way, contributes to explain the relatively slow progress of democratic approaches to school health education.

Introduction

Contemporary Western school systems have become increasingly complex in their attempts to accommodate ever more diverse pupil populations. Demands for documentation and for schools to excel in national and transnational (test) comparisons are increasing, as well as general pressure on schools and teachers to contribute in solving the 'ills of modern society' (Colquhoun 2005). Educating for public health constitutes one of these tasks.

Traditionally, health education in western schools has been informed by a biomedical understanding of health (Paulus 2005), focusing on the teaching of human anatomy, sex education and the harmful effects of smoking, alcohol, drugs, unhealthy diets and physical inactivity (Danish Health and Medicines Authority 2013). However, research in health education has long emphasized that health information and recommendations alone do not promote students' abilities to identify and act upon health problems (Nutbeam 2000).

According to the much quoted Ottawa Charter, young people must be involved and consulted in health educational programs (WHO 1986). Furthermore, "health" is conceptualised as a more complex matter, including both individual and structural dimensions, and is increasingly perceived within a holistic framework involving physical, psychological, social, ecological, and spiritual dimensions (Paulus 2005, Samdal 2012).

Transferring perspectives on health education to an educational setting, Jensen (Jensen 1997) argues for a democratic as opposed to a moralistic approach. The notion of democratic health education has been further developed in practice through reforms such as Health Promoting School Networks (Barnekow et al. 2006) and through theoretical

reconceptualization (Simovska 2012, Samdal et al. 2012, Simovska and McNamara 2015). However, although this dualist and rather simplistic division in its pure form seldom takes place in “real” life, a moralistic approach is based on giving risk-based health information and positioning students as passive recipients. In contrast, a democratic approach is based on a positive and holistic conceptualization of health, in which learning is based upon participation, critical reflection and dialogue between students and teachers (Jensen 1997). Basing health education on a moralistic approach is in line with more traditional school practice and seems manageable for schools to implement as short courses or project work. A democratic approach, however much in line with modern school ambitions, has yet to be accepted and implemented as legitimate and relevant school health education. As much (critical health) research implies implementing democratic approaches to school health education remains a challenge (Paulus 2005, Nordin 2013).

For instance, a recent Danish study demonstrates that health education, in the democratic sense, is rarely the focus of teaching and the teaching actually undertaken continues, in most cases, to rely on traditional, bio-medically based notions of health (Nordin 2013, Simovska, Nordin et al. 2015). The idea that health education is relevant and should involve a more democratic approach, in terms of methods and content, seems hard for schools to incorporate and prioritize (Nordin 2013) as a sustainable and legitimate part of school practice.

Depending on the focus of interest, explanations for this are formulated in different ways. For instance, Paulus (2005) believes the biomedical orientation is due to the fact that the driving force behind many school health initiatives (e.g. Health Promoting School Network) mainly comes from the WHO, which is concerned about better population health in a traditional biomedical sense. Others point to the fact that health and educational matters

are politically separate areas of decision making, thus hampering the creation of combined policies (Simovska, Nordin et al. 2015). A third explanation may be that “health” is not typically an independent subject (such as Maths, History, Language, etc.) within the Danish curriculum (this is also the case in, for instance, France and Canada), and therefore not intentionally addressed in practice. The topic health has its own content description and is, as such, compulsory. However, in practice, it is typically taught by means of occasional lessons (e.g. a drug expert visiting the school, the school nurse explaining sexual education, project week focussing on a health topic) or haphazardly integrated into other subjects (e.g. as part of biology and physical education classes).

If we specifically look at the Danish context, since 2004 the idea of democratic health education has strongly influenced educational policy related to school-based health education. In 2009, the guidelines for health education in Danish schools were formulated so as to comply with the principles of the Ottawa Charter for Health Promotion (WHO 1986) and with a democratic approach to health education (Jensen and Simovska 2005, Simovska and Jensen 2009). Attending to the complexity of health, the educational policy thus demands of schools to work with health education in ways that address such factors as 1) the causes and implications of being healthy/unhealthy, 2) visions and alternatives in relation to health and inequality in health, and 3) the promotion of action and change related to health (The Danish Ministry of Education 2014). Emphasizing factors such as equity in health, participation, democracy, and action competence, the guidelines are based on principles and values of health which are defined in a positive, holistic sense. These guidelines remain a part of the curriculum of the latest school reform, which furthermore includes more daily physical activity integrated into other subjects (The Danish Ministry of

Education 2014). As such, in accordance with these principles and values, the formal guidelines have been put in place for Danish schools to adopt democratic health education approaches. The problem still remains, however, that democratic health education in many schools is still not prioritised in the everyday school practice and implementation of the latest reform. This brings us to the particular focus of this paper.

In addition to the mentioned political, economic and pedagogic factors, we argue, other explanations exist as to why democratic health education in Danish schools face difficulty. This has to do with the current incentive structures and premises of school practice. Illuminated by an analytical perspective provided by symbolic interactionism schools represent more than particular societal functions such as the schooling of children and public health information strategies. Following for instance Berger and Luckmann (1966) schools may theoretically be perceived as institutionalised communities that function by virtue of socially practiced institutional rationales, which exist as patterns of behaviour (Berger and Luckmann 1966). They are established over time and are rooted in the historical, political, and social premises of the school as a societal institution. Institutional rationales simultaneously regulate and are reproduced through school practice and are thus, at the same time, products of what people do and constitutive for what actions people can and may be expected to take (Jenkins 2008). The social control inherent in institutional rationales is a form of power which is not necessarily individualized but which will typically be distributed among the people (i.e. teachers and students) present as reasonable ways to act. Institutional rationales thus constitute an integrated part of the social reality of schools to which individuals must relate, since particular routines and actions are legitimized through

them. In other words, Institutional rationales make it hard to imagine doing things differently (Berger and Luckmann 1966, Gulløv 2004).

Applying a symbolic interactionist perspective to qualitative data collected in a number of schools in which we have been involved in research and school health education interventions, we argue and describe how two types of institutional rationales act as powerful barriers to democratic health education, namely conservatism and neo-liberalism. These institutional forces emerge from historically generated conservative perceptions of what schools are and should practice, in terms of discipline, teaching methods and content (conservative approaches to curriculum); and neo-liberal discourses of accountability (standardisation, comparison, and increased testing). These forces, we argue, constitute a fundamental barrier to working with democratic approaches to health education in Danish schools since they, as institutional rationales, are reproduced by teachers *and* students in the everyday interactions and social reality of the school.

The papers' critical stance highlights repeatedly observed tendencies during our years of working with school health educational approaches in Danish primary and secondary schools. In this paper, we specifically draw on empirical data generated in two Danish primary schools to illustrate the school level outcomes stemming the broader systemic pressures of conservative approaches to curricula and Neoliberal frameworks of change and accountability.

Study design

Data generation

The empirical data consists of ethnographic field notes and group interviews with students generated between the winter of 2013 and spring of 2014. Two classes from different public schools, both situated in the same large city in Denmark, participated across two school years, in seventh and eighth grades (with students aged 13–15 years). One of the schools (school 1) had a diverse pupil composition in terms of cultural, ethnic, and socioeconomic backgrounds. The student composition in the second school (school 2) was more homogeneous, and mainly consisted of students of Danish ancestry, from more socioeconomically well-off families.

The data was generated in connection with a PhD field work including a short-term participatory health education intervention study (for a thorough description of the intervention study see Bruselius-Jensen et al. 2015) taking place in the same two settings. Three researchers were involved in the process. During the data generation, one researcher mainly remained in an observant position while the other two divided the practical work of the intervention between them and the responsible class teacher. The main focus of the field observations was on everyday school social interactions to which we return.

The intervention study aimed to develop a sustainable participatory approach to school health education. The goal of the intervention was to enhance students' critical awareness on the amount of health-related messages they come across in their everyday virtual life.

The paragraphs below elaborate the reflections connected to the production of ethnographic field notes as well as the evaluative group interviews related to the intervention.

Ethnographic field observations

The ethnographic field notes comprise 20 days of participatory observations from each school (Andersen 2005, Warming 2005). Ethnographic fieldwork is a means to acquire insight into how people live and understand their lives, and how social 'taken-for-grantedness' occurs and is reproduced in particular local communities, social environments or institutional settings. As a research practice fieldwork is a form of "disciplined attention" (our translation) which is shaped by the analytical and theoretical interests on which a given study is based (Hastrup 2010).

To be more specific, the fieldwork of this study was methodologically grounded in an interactionist perspective paying specific attention to the micro-social interactions of students' everyday school life and social relations in school (Järvinen and Mik-Meyer 2005). Attention was directed towards social activities and meaning making within the social community of the schools. The key areas of interest were social activities and meaning making during lessons and breaks and thus, the negotiations of meaning between and among the students, between students and teachers, as well as the context of these interactions (Järvinen and Mik-Meyer 2005). Besides a general focus on school social interactions, specific attention was given to students' perceptions of health (education) and to the types of health education explicitly and implicitly undertaken and negotiated by students during lessons.

Field notes or the field diary were hand-written at the school site and unfolded with more details on computer afterwards

Group interviews

The empirical data also includes six group interviews (approximately 30 minutes each), including a total of 40 students. The interviews were conducted as part of an evaluation of the referred intervention 'Health in Virtual Spaces' (Bruselius-Jensen et al. 2014) which was piloted at both schools. As shortly mentioned the intervention aimed to generate reflection among the students about how their individual and collective perceptions and practices of health were influenced by the frequent health messages to which young people are exposed in their everyday virtual lives (e.g. using the Internet in general and watching TV). It aimed to support a democratic approach to health education by involving the students in both data collection and the analysis and presentation of the findings regarding these health messages. The research activities were integrated into the subject Danish, incorporating traditional teaching methodologies like media and text analysis, the use of language presentations and other forms of expression. The interview questions dealt with the pupils' experiences with the intervention in general, its content, and the didactic methods used. The interviews were conducted shortly after the termination of activities to ensure that the pupils remembered as much of the material and the activities as possible.

Research ethics

In Denmark, no specific research permit is required if research data are not 'person sensitive', e.g. information such as name, address or ID number. Thus, a permit was not required for the data reported in this paper. However, throughout the study, considerations have been

made regarding the ethics of the research and the involvement of the students. In short, the assignments and the purpose of the study were formulated in terms that children of the participants' age could relate to and understand. Their parents were informed and gave consent and, although the data collection took place in the school context, which does not normally include voluntary activities, all pupils were given, on several occasions, the opportunity to withdraw from any of the research-related activities (Alderson and Morrow 2011, Wyness 2012).

To sum up, the research underlying this paper had an explorative ambition aiming to increase our understanding of the challenges related to implement democratic health education in Danish schools. In addition the ambition was to develop a democratic approach to school health education which could be sustainable and manageable for teachers.

While the initial data collection was designed to examine and evaluate the implementation of the Health in Virtual Spaces education approach, a major theme stemming from the data analysis suggested that broader forces related to curriculum and accountability were having a substantial effect on the local implementation of this approach. The analytical perspective of symbolic interactionism supported this suggestion. While we have, in the above described the theoretical outset of our understanding of institutional practices, forces and rationales, in the following we describe the analytical strategy leading to the findings.

Analytical strategy

The paper's analytical strategy is based on abduction (Alvesson and Skoldberg 2009). In this respect, the collection and analysis of empirical data are both preceded by theoretical studies and combined with theory as a source of inspiration for discovering patterns that lead to further understanding and new interpretations (Alvesson and Skoldberg 2009). Inspirations from Goffman (1961), Berger and Luckmann (1966), and Gulløv (2004) have formed the analytical framework allowing us to identify the social processes and the interpersonal dynamics that constitute institutional life and room for action in schools. Thus, our analysis of the fieldwork and interviews were conducted on the basis of a conceptualisation of institutions as social contexts in which human interaction is influenced by conventions for action, routines, social responsibilities, and status systems that are continuously formulated, defined, and negotiated by the actors involved (Gulløv 2004). The term 'institutional rationales' is thus an analytical construct based on our empirical data from these and other schools as well as the simultaneous readings of institutional theory and school analyses.

Supported by the analytical strategy and in accordance with the theoretical framework and assumptions, the themes of the findings consist of *interpretations* of the social processes of school life. Furthermore, they are informed by historical and contemporary theoretical readings about the school. Finally, the interpretations are informed by what has, during the last decades, occupied the field of education research, namely, the increasing supranational influences and political interest and interventions which extends deep into the practice field of the school (Moos 2006).

While this paper is by no means comprehensive as to the excessive number of interests, demands and outside forces influencing school practice and priorities, we find in our empirical data and on the basis on our focus of interest that conservatism and neo-liberalism represent some of *the* major forces prohibiting democratic health education approaches in schools. After a short introduction to conservatism and neo-liberalism we exemplify empirically how these forces are visible in everyday school practices and students' perceptions.

Conservatism in Curricula

An important theme in curriculum theory revolves around how schools and curricula function, either to advance social change through education (social empowerment), or instead replicate current social systems and inequities (curricular conservatism). Despite decades of scholarship documenting the conservative power of schools and curriculum, concerns about substantial class-based and race-based inequities in educational outcomes remain (Luke 2010, Lim 2014, Collins, Collins et al. 2015). Demands from special interests, entrenched interests, and historical precedent; can work to limit the extent to which the curriculum—and the way in which it is taught and assessed—can be changed.

In the Danish context, curriculum is largely defined at the Ministry level, with schools and teachers responsible for implementing curricular changes. Translating knowledge from the primary field of Health into curriculum, and then through learning activities into student knowledge, is challenging. When knowledge is recontextualised into pedagogic material, misinterpretation of the foundational knowledge can result in challenges regarding what gets taught and learned in schools (Macdonald, Hunter, & Tinning, 2007). While curriculum control at the ministerial level might suggest that broad changes to curriculum can easily be

made from the central authority, without concomitant support for changes in teacher preparation and professional development, as well as outreach to parents and communities substantial changes are likely to generate confusion and experience resistance from entrenched interests.

Neoliberalism

Similarly, Neoliberal policy frameworks regarding accountability can serve to limit the ability of schools to implement curricular change. In the context of education, Neoliberal policy is particularly concerned with efficient use of resources to leverage improved academic performance as measured by standardized assessments. In general, that means a carefully defined curriculum focused on measureable outcomes. This curriculum (and the assessments used to measure it) typically focuses on literacy and numeracy, and to a lesser extent mixes with a neo-conservative drive for the teaching of traditional western knowledge and nationalist citizenship (Wrigley 2014). This scripting and restricting of the curriculum and assessments can function to limit the flexibility regarding what subject matter is actively included in class, and narrows the scope of instruction as teachers attempt to predict what knowledge will be covered on the accountability tests (Berliner 2011). Further, standardized assessments and the pressure to show improvement can cause teachers to fall back on traditional modes of instruction, limiting the extent to which even change advocates can engage in new teaching and learning experiences. Of particular relevance to this paper is the re-alignment toward traditional academic instruction in literacy and numeracy, as exemplified under NCLB in the United States (McMurrer 2007).

In many ways, the traditionally conservative nature of the curriculum and schools has been strengthened by the neo-liberal agenda of assessment and accountability, which insists on an explicitly defined curriculum and connected assessments, with even progressive leaders retrenching to conservative practices (Ylimaki 2012).

While a full discussion of the conservative forces in curriculum, and the manner in which those forces might interact with a neoliberal accountability agenda is beyond the scope of this article, they do provide a lens through which we can look at our data to understand the barriers to democratic health education. Hence, this lens is applied in the following empirical analysis/illustrations.

Empirical findings: Rationales at work in the school

In the following, the two themes are presented as analytical headlines: 1) schools as formalized conservative institutions and 2) schools as constrained by neo-liberal conceptions of assessment and accountability. These themes, we argue, are powerful drivers of school rationales that discourage a stronger focus on democratic health education.

Conservative rationales in Danish Schools

Despite efforts to democratize instruction in Danish schools, many of the structures—both physical and intellectual—act as conservative forces, with instruction still largely teacher centred and instructionally traditional. Physically, the rooms have been constructed and decorated in accordance to specific tasks, activities and goals. Interior decoration express

the classification and hierarchical divisions of teachers and students and their respective actions (Gulløv and Højlund 2005). Although the architecture of many newer schools attempts to facilitate different types of teaching, democratic participatory processes and creative thinking, the expectations of many parents, teachers, students, and politicians are still connected to images of conventional school teaching in which the teacher is by the blackboard and the students sit quietly, facing in that direction. Despite this caricature, much of school practice is still quite conventional. In this respect, the point we wish to make is that the physical space of many, particularly older, schools supports conventional practice or even opposes alternative ways of teaching. Where instructors try to break out of the mould, societal constraints often work to limit the extent to which change can occur.

While the democratic approach to health emphasizes student engagement the data reflect implicit rationales regarding what content is appropriate (or inappropriate) for student engagement. For instance, it became apparent in the ‘Health in Virtual Spaces’ intervention that some types of content (photos) were not deemed ‘appropriate’ subjects for discussion and display within the learning context. When we asked students whether the photos they took actually captured and represented the amount and content of health messages they see in virtual spaces (regarding the body, food, and movement) some of the students’ responses highlighted the limited opportunity they had for complex conversations due to conservative visions of what it is appropriate to discuss in class.

Interviewer: “Do you think that we succeeded in getting a realistic perspective of the images of health and bodies that confront young people like you during your time spent on the Internet?”

Frederik: “No”.

Interviewer: “You don’t think so?”

Frederik: “No, there are a lot, like, pages on Facebook, for example that ‘Bacon and Boobs’ and things like that where there are women’s bodies all over the place. There are a lot of those but in this project there haven’t been any photos of that.”

Interviewer: “Only one [student] took that kind of photo.”

Markus: “Yes, that was one in our group, but then the next day the photo had been removed.” (Interview school 2)

Later in the same interview, the interviewer inquired into the absence of photos of bodies, to which student 2 replied *“Well, I don’t think it belongs in school, so that’s ... it comes up anyway (on Facebook sites) but you don’t want to bring it in [to school]”*.

These statements illustrate one of the socially accepted norms that limit teacher and student engagement regarding health related topics. In this case, nakedness or sexualized photos are judged by participants as not belonging in school, despite the physical and sexual health related relevance of such photos. Although, as researchers, we allowed for any kind of photo to be taken under the headline ‘Body, Food, and movement’, both students and teachers viewed the one photo of a naked woman’s upper body as unacceptable within the school context.

Efforts to include more democratic pedagogical attitudes in Danish schools have gradually been incorporated in the curriculum, specifically around the idea of strengthening student involvement, participation in decision-making, and subject combinations. Generally, these efforts represent an ideal of the holistic and self-acting human being (Schmidt 2007) situated within a broader personal and societal context (Wright, & Burrows, 2004; Fitzpatrick, 2005), much in line with the ideals of critical health pedagogy (Jensen 2010). Nevertheless, the school remains a conservative institution with strict measures of reward and punishment along traditional curricular and behavioural lines. These explicit measures are slowly being replaced by an emphasis on intrinsic motivation and inner control or self-discipline, conceptualized by Fendler (Fendler 1999) as *developmentality*, which illustrates a complex and not yet clarified relation within the school enterprise between visions of emancipatory disengagement and diverse and effectual forms of instruction or, as Schmidt terms it, discipline (Schmidt 2007). Efforts to make schools more democratic, for instance, through the introduction of democratic health education, remain constrained by their history as conservative institutions (regarding both behaviour and curriculum). Such conservative practices still weigh heavy on school practice.

In addition, changing school practice may be further challenged by the interpersonally recognized rationales that extend beyond concrete situations and persons and which function as abstract expressions of norms, routines, and expectations of, for instance, the nature of learning (Gulløv 2004). The quotes below are the responses of seventh-grade students (13–14 years old) to questions concerning ‘Health in Virtual Spaces’. The questions concerned students’ conceptualization of learning within the project, and whether their experiences were ‘eye opening’ in relation to the educational goal of the project (to create

awareness of the amount of and impact of health messages displayed on the Internet and social media).

Yad: “Well, I don’t feel like we learned anything” [from participating in the project].

Interviewer: “You didn’t learn anything? But how do you understand learning?”

Yad: “It is hard to explain but I just do not feel like there is anything that I have learned, like ...”

Jasmina: “No, me neither.”

Interviewer: “There hasn’t been anything new?”

Yad: “Not really.”

Student 2: “I think new information is missing. We may have been thinking more about the [health messages on Internet], but I don’t think we learned anything about it. Maybe you could have just told us about health or something like that.... You just didn’t come out of it with any new knowledge.” (Interview school 2)

These students’ replies illustrate socially accepted norms and expectations of how and what students need to learn in school. The quotes illustrate how they did not recognize knowledge about their own practices and the impact of media information as applicable health learning within the school context. Further, it highlights the disconnectedness—at the student level—between education as experiential, and education as concrete instruction.

They would have rather been taught ‘something about health’; that is, being informed about

health, rather than develop their own understanding through examination of their direct experiences. This again exemplifies how traces have been left in the institutional space of the school that create opportunities and limitations for its contemporary users, teachers and students, to engage in democratic teaching methods and to influence curricular content.

Rationales of Neoliberalism

Neoliberal discourse and conceptualization of learning, knowledge, and teaching are becoming more dominant and influential on school practice in Denmark. In line with the quotes above, the following exemplifies in even more detail how the students of this study perceive learning and, thus, why a democratic and open-ended health education approach in some ways is considered an obstacle to their 'real' work.

Interviewer: "Is your experience that this project was more relevant to your lives than an ordinary Danish school project?"

Anna: "I don't know. In fact, I like ordinary Danish lessons more. I think I learn more from that; it is more relevant I find."

Interviewer: "Ok, so this is in relation to what you need to learn for the exams, is that what you mean?"

Anna: "Yes!" (Interview school 2)

Good marks and strong test results are significant for both teachers and students. Their importance is repeatedly emphasized in curricular materials. In the Danish primary and secondary school system students do not have report cards or receive grades until 9th grade (app. 15 years). However, in seventh grade, where marks do not yet count both classes had started 'practicing' the formal grading system. Hence, in several instances, we observed how

teachers indicated the mark for a particular assignment. Practice tests from higher grade levels were also often used. The same activities occurred in eighth grade, but even more frequently with most assignments being graded and recorded on a grade sheet. Tests were still on a trial basis but administered more often than in seventh grade. This practice had the purpose of preparing the students for the “real thing” in ninth grade and the marks were taken quite seriously, even though they were not official indicators of student progress or ability. Students were interested in each other’s marks and lively discussions took place every time marks were given. The students with high marks were obviously proud, some because they could expect an extrinsic reward for their good marks from their parents, such as the boy at school 1 who, after a ‘mark practice’, eagerly told his classroom neighbour, “If I get three A’s I get a new computer screen!”

Over the last two decades, supranational agencies such as the Organisation for Economic Co-operation and Development (OECD), the European Union (EU), and the United Nations Educational, Scientific and Cultural Organization (UNESCO) have increasingly influenced European education policies at national levels. In an effort to increase efficiency across education systems, these organizations have collectively supported a test-based approach to learning assessment and a focus on the accountability of schools and educators for improving achievement as measured by these test scores. This influence constitutes an important part of the context in which teaching practice and measurement of learning is legitimized (Moos 2006, Grek 2009, Meyer and Benavot 2013, Sellar and Lingard 2013). As policies created in the wake of these changing perspectives are implemented in school practice, they operate as social technologies that create a controlled space regarding how we think and speak about teaching and learning (Biesta 2007). In the Danish context, the

concrete operational procedures for these social technologies consist of individual student programs, increased testing, and demands for documentation.

The argument here is that the focus on grades and testing is now a governing factor in Danish schools. Conservative and neo-liberal discourses encourage measurement, testing and other types of evaluation and documentation providing 'evidence' for learning outcomes (Ball 2003, Krejsler 2007). Test results and grades become a competition parameter and a measure of comparison that encourages standardization. When the delimited conservative academic qualifications mentioned above are combined with standardization and testing, learning becomes measurable (Krejsler 2007), which is again a central concept in the idea of an education market (Meyer and Benavot 2013, Torres 2013). Finally, as the stakes regarding performance at the individual, classroom, school, and national level are increased (for example through international rankings of student performance like TIMSS and PIRLS), the pressure to revert to explicit instruction of the defined curriculum is greatly increased (Biesta 2007, Biesta 2009).

Although schools have been trying to incorporate innovative and less traditional teaching methods and content, conservative and neo-liberal forces have become strong currents in school practice, particularly for the higher grades. In this respect, our data are consistent with those of Moos (Moos 2007), in that conservative and neo-liberal attitudes towards learning and teaching have a consequence, easily pressuring schools and teachers to choose content and didactics that, for instance, 'guarantee' the desired test results. This type of focus was prevalent, particularly for school 1, where many students performed relatively

poorly. One example is expressed in the following field observation, which takes place while the students are taking a Danish rehearsal test in preparation for next year's real exam

Teacher xx tells me that she is trying to teach the students how to take these tests and provide them with strategies so they can pass the test without getting very low grades, not understanding the text or reading so slowly they do not have the time to complete it. That is why she is conducting these rehearsal tests, which are similar to the one they need to take in ninth grade. She has many ideas for other types of teaching that she would like to try, but she sticks to this because of the compulsory tests. (Field observation school 1)

The two schools in this study were very different in terms of the students and their families' backgrounds, the social interaction between students in school breaks, the relations between students and teachers, the teachers' methods and behaviours, as well as the schools' physical spaces. However, despite these many differences, in terms of context and the academic level of the students, they worked according to the same national politically defined guidelines and management structures. To use Bernstein's (Bernstein 2000) notion, *recontextualized* in the social world of schools, the political guidelines are transmitted as similar institutional rationales of understanding of legitimate and important knowledge and learning. Referring to the excerpt immediately above, the only difference is: teachers in school 1 were preparing their students to pass the pending tests. The teachers in school 2 were preparing their students to do well in them.

The institutional space of the school is full of prioritizations that, along the way, have been forgotten as such and given special, unnoticed authority (Gulløv and Højlund 2005). In line with Moos (Moos 2007), our claim is that social technologies brought about by both

conservative forces and neo-liberal discourses have become a type of institutional power (Fendler 1999) taking root within the classroom. The power of the social technologies is invisible, built into the school's practice as plans, didactics, and social norms, which, during the last decades, have been negotiated between school actors at various levels. The social technologies of testing and detailed documentation now appear as more or less unconsidered, non-negotiable, and taken for granted social practices involving both teachers and students (Moos 2007).

Discussion

The rationales described in the above are counterproductive to at least three central principles within democratic health education.

1) First, they conflict with the aim to shift the concept of health from a biomedical approach to a broad and democratic approach. As mentioned health as a school subject has traditionally been about hygiene, sexual education, diet, and physical education, expressed in the formal teaching and general disciplining of students. This focus aligns well with the conservative views of curriculum and neoliberal conceptions of efficiency; it deemphasizes concepts such as democratic health rights, mental well-being, and addressing structural barriers to health. In addition, this influences health education in the direction of prioritizing predetermined and measurable academic content (Holm 2007), thus promoting the traditional bio-medically informed health education taught by means of conservative didactics.

Our findings demonstrate how these tendencies also shape students' expectations. The activities within the project 'Health in Virtual Spaces', on the one hand, aimed for a democratic approach to health education while simultaneously adapting to the school's curriculum. Still, the students either found the content too simple, in that they already knew what health messages they were exposed to because they obviously saw the images on the Internet and thus did not learn anything new, or they found it irrelevant to their school work and exam preparation for the following two final years of school. We explain this attitude as the result of pressure on teachers and students to do well in tests and by comparisons of institutionally valued types of knowledge. The two rationales combined made neither the teachers nor the students consider the relevance of a broad and positive concept of health as an educational aim.

2) Second, the institutional rationales oppose the use of participatory approaches to health education by emphasizing individual learning and accountability. In line with the aims of democratic health education, participation was an essential feature of 'Health in Virtual Spaces'. The teaching was therefore based on students studying their own practices, with no predefined or correct answers and with very limited health information given beforehand. However, the way the students expected to receive 'new information about health' revealed the subtle conservative institutional rationales and expectations of how a good student should behave and learn. This indicates a clash in the perceptions of what school and learning are about and how knowledge is transferred, thus hampering participatory learning and self-reflection as a central element in health education.

3) Finally, the rationales confine the scope of what health knowledge and learning may be within the school context to specific content, rather than a broader values and behavioural approach to health. As Biesta (2007) argues the increasing demand for evidence-based education has produced a democratic deficit in education. If education is only used to transmit acknowledged information in accountable ways, no room is left for democratic debate (Biesta 2009). Since standardized tests are characterized by their lack of analysis, synthesis, and appraisal (Moos 2007), the element of *bildung*, defined as focal in democratic health education, faces difficulties. In other words, health learning that cannot be tested or quantified along with other types of knowledge related to 'non-testable' subjects (will continue to) struggle to gain legitimacy.

Conclusion

In this article, we argue that the institutional school rationales of conservatism and neoliberalism make up a strong explanation of the difficulties faced by democratic school health education efforts. Although serious work is being done by scholars, practitioners, and policy makers in Europe and abroad, to develop and implement democratic approaches to health education in schools, much of it merely ends up touching the surface of school practice as the focus on democratic health education is overruled by the priorities of the next graded course in line or by formal learning activities.

Our findings demonstrate how conservative and neoliberal tendencies enforce these priorities and work as barriers to the application of more democratic school health education as they are produced and reproduced by teachers *and* students as indisputable

and unrecognized institutional rationales. These rationales act as barriers by working in opposition to at least three central elements within democratic health education, namely a broad and positive concept of health as a point of departure, the element of participation, and the element of promoting general knowledge in the sense of *bildung* (general education).

Implications for practice

The analysis and discussion of this paper, although primarily based on the Danish context, may provide deeper insights into the challenges ahead and the considerations required for endeavour to promote sustainable democratic approaches to school-based health education. Because of its image as an affluent and thriving society Denmark is frequently held up as a model for other countries to examine. As such, it is important to interrogate and share critiques of what is increasingly becoming a more constrained educational system. Thus, we argue that health education approaches must not only comply with current teaching practices and students' academic levels, they also need to modify existing rationales around the institutional context, including teachers' *and* students' expectations about health education and what health learning should be about.

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