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L. Burrows

University of Otago, New Zealand

Jan Wright

University of Wollongong, jwright@uow.edu.au

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Prescribing practices: shaping healthy children in schools (Draft only – not for citation)

Lisette Burrows and Jan Wright
University of Otago and University of Wollongong
lburrows@pooka.otago.ac.nz
jwright@uow.edu.au

Current concerns in New Zealand and abroad about the health and well-being of young people have generated a raft of government-sponsored and educational policies and practices geared towards the production of trim, taut and fit subjects who choose wisely from the range of risky ‘options’ available to them in avowedly new and changing times. These initiatives yield consequences for children and young people who are increasingly being urged, in Foucault’s terms, to conduct “...a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being...”(1997, p. 225) in an effort to ‘become’ the imagined healthful, agentic citizen. Drawing on poststructuralist theoretical resources and perspectives from the sociology of childhood, we explore the ways these practices are implicated in the constitution of children and young people as social actors. Empirical work with children and teachers, media and policy analyses, together with an interrogation of contemporary curriculum imperatives, inform our analysis with Australia and New Zealand providing the primary contexts for our investigation.

The health context

Shaping the attitudes and values of the young is a weighty task, arguably made more so by the sheer volume and range of perceived ‘risks’ to children’s health in contemporary times (Giddens, 1991; Leahy & Harrison, 2004; Lupton, 1995). Alcohol, drug-taking, smoking, bullying, the sun, and stranger danger are just a few of the concerns dominating public discourse, and in the past decade panics generated around ‘childhood obesity’ have created unprecedented concern over children’s eating habits and physical activity levels (Campos, 2004, Gard, 2004; Gard and Wright, 2001, 2005) together with warnings of the dangers implicit in their video game-playing and internet practices (Song & Anderson, 2003). One of the key discursive themes emerging from analysis of the reporting on children’s health is the twin positioning of young people as perennially ‘at risk’ of a range of health-inhibiting substances and behaviours but also as ‘risky’ or ‘dangerous’ because of their propensity to indulge in those very practices that threaten their own and others’ wellbeing both now and in the future (Burrows & Wright, 2004a, 2004b; Kelly, 2000; Leahy & Harrison, 2004).

One of the consequences of framing health concerns within developmental arguments that posit ‘early intervention’ as the key to healthy futures is a proliferation of agencies both within and outside of schools interested in participating in the production of healthy children. The sheer range and volume of these initiatives and the diverse philosophical orientations of groups who seek to work with school-aged children would seemingly produce confusion and uncertainty over what counts as good ‘health’ and how to go about achieving it. Diversity aside, however, our interrogation of a range of school-based

and public health resources used in schools, would suggest that one thing many current initiatives share is a commitment to a neoliberal “it’s up to you” notion that positions individuals as primarily responsible for crafting the kinds of lives and dispositions that suit them best (Crawford, 1980).

Lupton (1995) draws on Foucault to discuss the ways in which public health discourses and practices work to both constitute and regulate understandings of ‘normality’, ‘risk’ and ‘health’. She argues that “Public health practitioners make claims of truth and use these claims for strategic purposes just as do members of the medical profession” (p.4). In the contemporary health context these processes are readily apparent. As we argue in this paper, it would appear that eating ‘well’ and exercising daily, for example, have become something of a ‘moral responsibility’ for most adults. In the case of very young children, presumed incapable of making informed decisions about health (Mayall, 1994), parents and arguably mothers, in particular (Burman, 1991; Urwin, 1985), families and communities are increasingly drawn into the fray urged to change their own behaviours for ‘the good of the child’.

Whether children or the adults who ‘care’ for them are targeted, central to the work of both government and private agencies is a commitment to the notion of a subject who can choose – a subject who can make wise choices amid the plethora of ‘risky’ alternative open to them as members of what Giddens (1991) calls an ‘options generation’. In Foucault’s terms, individuals are encouraged to conduct “...a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being...” (1997, p.225) in an effort to ‘become’ the imagined healthful, agentic citizen.

The fat lands

In the current context (for Westernized nations at least) the obesity epidemic (or the idea of one) is disproportionately influencing the way young people are being constituted as either ‘healthy’ or ‘not healthy’ citizens and subsequently the kinds of operations they are encouraged to apply to their ‘selves’ (Gard & Wright, 2005). In 2004 Australian prime minister John Howard announced that the Australian government would spend \$116 million over four years on addressing declining activity and poor eating habits among children (e.g. see ‘Building a Healthy Active Australia’ package and linked initiatives such as The national ‘Go for 2&5 Campaign’ - <http://www.healthyactive.gov.au/>). The justification for this investment rests on an assumed connection between escalating rates of obesity and particular ‘lifestyle’ practices, including a decline in physical activity, over-consumption of fatty foods and too much television watching. New Zealand’s Ministries of Health, Education and Sport and Recreation are allotting similarly large amounts of money to state sponsored programmes and initiatives in the food and physical activity realm (e.g., 5 plus programme APPLE programme, Healthy Eating-Healthy Action, Push Play). The current Minister of Health has just announced that an undisclosed sum will be spent in schools on programmes and policies designed to reduce the escalating rates of childhood obesity (Hodgson, 2005). These policies and the programmes that are generated from them are invariably geared toward either getting children ‘more active’ or changing their eating patterns. Interestingly, while many government policy and strategy ‘titles’ are framed in terms of ‘lifestyle’ and/or ‘physical activity’ recommendations, the content of these documents reveals a thinly disguised causal link to ‘obesity’. For example, Australia’s Physical Activity Recommendations for

Children and Young People opens with a discussion about what the recommendations are yet by page two, the text is reporting facts about overweight and obesity (see <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhealth-strateg-active-recommend.htm>). Similarly New Zealand's APPLE – A Pilot Programme for Lifestyle and Exercise's opening statement on its webpage reads: "Obesity is increasing in New Zealand, and there is evidence to suggest this is occurring not only in adults but also in children and adolescents..." (<http://www.otago.ac.nz/diabetes/research/apple.html>).

Popular media sources too, are riddled with warnings about escalating rises in childhood obesity. A cursory glance at daily regional newspapers yields a surfeit of articles on childhood obesity (Burrows, 2005), while From 'Get Kids Active', a new internet site set up to provide resources to parents and teachers, we read "Obesity is one of the nation's top killers...Unless New Zealand comes to grips with its epidemic of childhood obesity, you're certain to pay more for health insurance" (<http://www.getkidsactive.com>). A recently released parenting magazine 'Kids Life' devoted their inaugural issue to stories about childhood obesity. Article titles in issue no. 1 include, "Childhood obesity: Through thick & thin"; 'Growing active children', "At Large", "Survival of the fittest" and "Does size matter?" In each of these sources, children are regularly represented as fat and getting fatter. They are either overweight now or 'at risk' of becoming that way and the reasons are inevitably put forward as being straightforwardly true, that is, too much food, too much television, lack of regular physical activity and the advent of new technologies. Even where contradictions and uncertainty around the 'truth' of obesity claims *are* acknowledged, these are invariably minimized in both professional and popular cultural media. For example, the opening sentence in Brown's (2003) article in 'Kids Life' reads, "There is much debate about the obesity epidemic in recent times". The second sentence reads, "We are gaining weight at the rate of a gram a day..." (p.6).

Several have proffered critiques of the epidemiological research that validates such claims and the veracity of one to one causal links between particular practices (e.g. television watching) and obesity so often made (Campos, 2001; Gard, 2004; Gard & Wright, 2005). Nevertheless fears around what is now being regarded as a world-wide obesity pandemic persist. As Gard & Wright (2005) have persuasively argued, it is difficult to envisage the fat child as anything other than 'unhealthy' and/or morally defunct in a climate where fear of fat has reached such epidemic proportions. There are several features of the obesity epidemic discourses worth noting here. First, the extent and repetitive nature of reporting on obesity matters establishes an understanding that everyone is at risk. Unlike some other 'diseases' obesity can strike anyone anywhere. Secondly, the widespread use of descriptors like 'alarming' 'phenomenal' epidemic' 'escalating' and 'serious' in reporting, works to construct a climate of 'fear' around both the speed at which the 'disease' is spreading and the deleterious consequences that will inevitably follow. Thirdly, the certainty with which 'facts' about obesity are reported is astonishing, especially so, given the acknowledged uncertainty that pervades much of the scientific evidence fuelling the 'facts' (Ross, 2005). The New Zealand-based organization 'Fight the Obesity Epidemic' (FOE) illustrates many of these features, reporting 'The facts about obesity' in the following way:

Many of us are eating too much junk food, not getting enough exercise, and getting fat. New Zealand children are becoming obese

and getting Type 2 diabetes. Obesity contributes to premature death, serious diseases and increasing health costs.
(<http://www.foe.org.nz/facts.html>)

Headlines in the Otago Daily Times (a New Zealand regional newspaper) include: “Quarter of children in Otago overweight or obese” (18/07/05) and “obesity killing Otago people” (9/08/05). In Canada we read, “We are among the biggest eaters in the world and nowhere is the problem more apparent than St Catharines, Ont., the fattest city in the country” (Picard 2001: F1). Australian reporting suggests that “Childhood obesity is on the rise with no end in sight. There has been a steady and dramatic increase in obesity for children six to 17 years of age in the past 20 years, more than 50 percent in the six to 11 age group. Childhood obesity is, indeed, a very serious issue” (‘Nintendonitis’, cited in PDHPE, Lifelong Physical Activity, Stage 4, p.8).

It is within such a climate that children are being offered a number of ways to *understand* themselves, *change* themselves and *take action* to change others and their environments. It is these resources for change, their nature and their effects that we want to examine. While cognizant of the role popular media plays in conveying understandings of health and wellbeing in children’s lives, in this paper, it is the particular policies, text resources and web-based sites that schools engage with that we focus on because schools are one of major sites where public and private health providers and increasingly corporate agencies focus their energies. We are interested to interrogate those resources in terms of the meanings they construct and the work they do and their likely effects for children as they craft their identities in relation to health.

Schooling healthy children

As holding pens of large numbers of children, schools have always been used as sites of governance, targeted for an impressive range of health intervention and prevention programmes (Burrows, 2001; Evans & Davies, 2004, Kirk, 1997). Even when health education programmes per se were not prescribed as part of the official curriculum, public health providers have played pivotal roles in New Zealand schools, providing such things as ‘free milk’, ‘free dental checks’ and inoculation against a range of childhood diseases (Burrows & Wright, 2004a). In the past decade, a shift from a biomedical view of health (where health is regarded as a matter of the presence or absence of physical illness) to an understanding of health as encompassing a broad range of personal, social, spiritual and cultural ‘elements’ (Robertson, 2005; Tasker, 1996/97) has been accompanied by the entry of a broader and more diverse set of personnel and curriculum imperatives to schools (e.g. mental health promoters, sexual health activists, drug counselors etc). A recognition of the changing media, socioeconomic, cultural and social contexts within which young people ‘grow up’ (Abbott-Chapman, 2000; McRobbie, 1994; Tinning & Fitzclarence, 1992); has also assisted many health and physical educators to shift from a brand of pedagogy that says “this is what good health entails...go out and get it” to an emphasis on encouraging children and young people to become critical consumers of health messages, to decide for themselves what health means to them and how best to achieve it and to do so in context – that is, in relation to

the constraints and possibilities afforded them in their unique settings, both local and global (Culpan, 1996/97, 2000; Robertson, 2005, Tasker, 1996/97).

The kinds of resources attached to the Health and Physical Education in the New Zealand curriculum include a string of 'Curriculum in Action' booklets on topics ranging from body image to Olympic ideals, kohitanga – Getting on together, and 'making meaning in health and Physical Education'. Two features of this collection are worthy of note. Firstly, most of the Curriculum in Action resources draw explicitly on excerpts from popular media to provoke discussion about health issues among children – a discernable attempt to connect students up with events and practices occurring 'out there' in communities, nations and, in the case of the Olympics and the 'Obesity epidemic', the world. Secondly, they draw on a Health Promotion Action Cycle devised by one of the chief curriculum writers (Tasker, 2000). This is a series of sequential questions students are asked to think about in relation to any health issue leading to a 'taking action' component where students presumably take what they have learned and apply it to generate change for the better in either their own or others' lives (See Robertson, 2005 for a full description of this process). That is, students are required not only to interrogate health issues and outcomes but also to *use* what they have gleaned from their enquiries in tangible ways.

On the surface, these pedagogies seem to imply a shift from individualistic notions of health as an 'up to you' kind of endeavour to a notion of health as a communitarian affair and one subject to a range of different interpretations and enactments aligned with the particular sociocultural characteristics of a student's environs. Furthermore, the HPE curriculum clearly represents a vision of children who are capable of 'taking action' and being more agentive as 'consumers' of health oriented messages and products. However, we will suggest that in the context of the obesity epidemic, much of the potential this curriculum yields in terms of regarding children as social actors is diluted. Further, despite an avowedly more 'holistic' notion of what health entails, in an 'obesity' laden environment, much of the focus in schooling remains on practices that impact on physical health – specifically on eating and physical exercise.

Prescribing practices

We turn, now, to several examples of the resources children have available to them via internet, school textbooks, booklets and private providers like 'Life Education' to make sense of their health status. We interrogate these resources for the notions of the 'good child' and 'good parent' (subject) they support, for the ways they offer resources to assess, value and evaluate good or bad behaviours and for the kinds of prescriptions they provide on how to become that subject.

The tools

Firstly, the resources provide some fairly clear prescriptions regarding how one can come to know oneself. *Self-assessment* is the key pedagogical tool employed across a range of internet and text-book resources. School-based and youth-targetted websites are replete with BMI calculators that afford ready answers to the question 'are you overweight or obese?' In NZ, the 'Get Kids Active' site, until recently, has supplied a free on-line

obesity counter. *Self-monitoring* provides another route towards knowing oneself as a 'good' subject. In the Life Education Trust Take Home Work Book 8 (Life Education Trust, 1996) for example, a page is divided vertically into two sections. In one column students list the specific foods they have eaten for each hour throughout the day. They accompany this with a list of the exercise they have done that day. The question 'How's your balance?' is addressed via calculating total kilo joule input (food in) and output (exercise done). Here a thorough monitoring of self-practices is encouraged via use of daily lifestyle charts.

In both Ministry of Education resources and Life Education Trust resources (e.g. year three 'Feelings Diary') children are asked to submit *weekly* rather than daily lifestyle charts that record not only, inputs and outputs related to food and exercise but also their feelings, emotional states and their contributions to the health and wellbeing of others. In the Curriculum in Action series booklet 'Choice food!' for example, year 7 and 8 children complete a food diary that not only requires them to list food items consumed but also to signal why they ate it, who they were with at the time, what they were doing when they ate it, how they were feeling and what was the occasion during which the food and/or drink was consumed (Ministry of Education, 1999, p.11). Lifestyle fact files like these are a popular pedagogical tool across many spheres of the health education curriculum, but seem to lend themselves particularly well to imperatives around 'nutrition' and 'exercise'. It is an intense self scrutiny and analysis of relationships between behaviours and contexts within which they occur that is required to participate in these kinds of activities, one that involves a constant monitoring of what one is thinking as well as what one is doing. Here teachers are engaged in pedagogies of student surveillance and constant monitoring (via submission of student journals) of children's behaviours *and* students are also, simultaneously supplied with the tools to perform these surveillant practices on themselves, encouraged to look at food and calculate exercise in precise ways that yield results which in turn may generate further 'actions'.

On the one hand, these kinds of projects could be regarded as a genuine attempt to acknowledge and provide children with opportunities to regard their practices 'in the round', as crucially linked to the contexts of their lives. On the other hand, these kinds of imperatives point to an expansion of the realms of a child's life and dispositions requiring surveillance and/or monitoring (Seedhouse, 1997). Furthermore, these kinds of learning activities can only gain purchase in a context where abhorrence of 'fat' has become the norm. The saturation of popular media and professional missives with commentary and images suggesting everyone, everywhere is becoming fatter set alongside an abundance of images portraying the 'ideal' slim, trim and terrific subject (Bordo, 1992; Markula, 1997, 2000; Tinning, 1985) works to construct particular desires *and* fears. The motivations to perform the kinds of self-surveillant and monitoring practices discussed above is in part derived from a core 'ideal' set against an abject subject, a subject that current discourse suggests few would want to emulate – that is, the person who is 'fat'.

Comparisons with the abject subject are encouraged in many website resources linked to school programmes as well as in popular culture (e.g. Augustus Gloop in 'Charlie in the Chocolate Factory') as yet another tool for coming to know oneself. In much the same way a blackened lung or rotting teeth promote revulsion and fear associated with smoking, greasy, oily food *and* people encourage children to be disgusted by fat and

pathologically fearful of it. The images accompanying obesity stories in 'Kids Life' for example portray a sedentary, potato munching and coke-drinking boy in an armchair accompanied by pictures of him in his swimming costume replete with rolls of fat descending from the neck down. In the text of this story we read, "Obesity is a phenomenon that appears to have begun to rear its *ugly* head sometime in the 1980s ..." (Brown, 2003, p. 6). An Australian school health resource 'Healthy Bodies, Happy Kids' (Tasker, 2003) conjures up three characters – Ollie Oil, Oilyan, and Oily Onlooker who symbolize the 'abjectness' of fat accessibly for children from junior to upper primary school levels. Ollie Oil has a spotty face, appalling hair and is featured sitting down, not smiling and eating chips. Oilyan is a dripping, viscous, gooey humanoid with one hooded eye while Oily Onlooker is a spotty kid with bad posture carrying a packet of chips with a pot of chips on his hat. In the Primary health and safety curriculum children are invited to watch and evaluate characters like Ricky Finger licker, Adam Greasespot and Lisa Lipsmacker who consume vast quantities of risky food (like chocolate covered doughnuts and fried sausage sandwiches). In a further effort to bring home the message that fat is revolting on p. 19 we read:

Very often we can recognize fatty foods just by their feel and texture, Usually fatty foods will leave clues about what they're made from... Drag one end of the butter across the lunch paper. Have the students observe that the butter leaves a greasy trail on the paper. You may have one or two students touch the butter trail to verify that fact (Have the students wipe off their greasy fingers with the tissues) (Fischer, 2004, p.19).

Change agents

Of course a range of scary tactics and self-diagnostic tools for evaluating one's current state of health or wellbeing does not necessarily help children know what to do about it if their investigations have yielded poor results (e.g. too fat). Thus, together with the instructions to understand, know, assess and diagnose themselves we find that young people, in the guise of fostering agency, are also increasingly instructed to act on themselves, changing bodies, habits and dispositions for the better. An abundance of ideas around this are provided via institutionally based resources, internet sites hooked up to school programmes, popular media and of course via the expertise provided by public health promoters and other agencies working within and alongside schools. Many of these initiatives are designed to match the ways in which parents and children currently access information (e.g. popular magazines and child-friendly interactive web sites) These projects for change range from dietary plans and exercise regimes to detailed prescriptions for new 'lifestyles'. Schools, parents and children themselves are variously accorded responsibility for enacting these change projects.

Teachers' practices

News headlines like "We just need to start doing something *real* about obesity. Like schools bringing back compulsory PE until the seventh form" (FOE, 2004) leave one in little doubt about the pivotal role schools, and teachers, in particular, are presumed to play in the inculcation of healthy habits in the young. Across Australia and New Zealand

teachers are applying a range of practices to children in an effort to assist them to change their lifestyle habits. In some schools, lunch-box inspections are being undertaken by teachers (O'Neill, 2004) and in others free fruit is being dispensed to those unable or unwilling to include the obligatory apple in their lunch box (O'Neill, 2004). In Boston, some schools have instituted 'health report cards', where children's weight and fitness levels are recorded and sent home to parents who are then urged to 'take action' (CBC radio, 2003). In Australia, Leahy & Harrison (2003) report on the phenomenon of 'fat laps' in primary schools. Here children identified as exceeding recommended body weight norms are required to run around the school field in their lunchtimes. Both children and their teachers refer to this practice as 'fat laps'. While we have no empirical evidence of practices like 'fat laps' in New Zealand, the mandating of daily exercise in primary schools via new national education guidelines (Mallard, 2004) is one government initiative shared with Australia – one that not only assumes all children or primary school age need to be 'more active' but one that squarely places the responsibility for ensuring this happens on already over-burdened junior schools.

Whether explicitly stated or not, fuelling many of these initiatives are notions that children are and can be change agents for parents, families and communities. Examples of children 'taking action' to change school canteen food, alter the food shopping habits of their families, and in some cases radically reshape the family's lifestyle (in terms of meals eaten, exercise taken and so forth) are broadcast on health promotion websites, radio discussion sessions and in national newspapers. The paradox is that some health promoting schools continue to earn revenue through cake stalls, cheese roll and chocolate bar sales while simultaneously requiring children to change the eating patterns of themselves and their families (Martin, 2005).

A discourse of disadvantage adds further weight to initiatives geared toward children changing families. Headlines like "Schools to fill values void as parents fail" (ODT 19/08/05) point to an urgency around ensuring children have the resources necessary to make 'good' decisions when the material or social conditions of their lives aren't conducive to doing so. A male Australian teacher in the Australian Life and Physical Activity Project study (2002) discusses making a 'difference' in the lives of students who are likely to leave school early in the following way:

... Even in, you're talking about, we'll go back to the nutrition thing, if you can tell a kid that hey it's not a good idea to have McDonalds, breakfast lunch and tea, and they take that on board and they go home and they say 'oh mum you know like Mr. Westwood said that, you know blah blah blah', I think things like that, because they're life skills that you can use whereas you know other subjects, you don't, you need to do them and you, they're going to help you in life...

The likelihood that unhealthy behaviours will be recycled through generations, a premise well established in anti family violence discourse, also frequently appears in teacher talk. One Australian teacher describes the problem and the anticipated consequences like this:

Well, look at the rates of obesity in Australia. It's huge, you know, and if you don't start with the students or the young ones, it's just gonna keep

going, going and going. It's easy enough just to go down and buy fast food and things like that, but they need to understand that, because they will be adults one day, these students and these kids, so if they don't understand now that they need to have vegetables, cooked at home, not just vegetables and Chinese every night, "Oh I'm having the vegetables," whatever. They need to understand that they have to do that because one day they may be even parents, and they may have to try and get the idea across to the kids, because a lot of these kids are probably in a cycle now. (Mr. S., Interview 2, 2002)

Parents as first teachers

With very young children the route toward changing their practices and by implication, those of their families and communities is often less clear. As sociologists of childhood have pointed out, children, have until relatively recently, in Western contexts, at least, been largely regarded as 'becomings' rather than 'beings', as not yet fully formed, nor capable of making rational decisions in their own best interests (Mayall, 2004). In the case of young children, parents and/or caregivers are often drawn into the 'change project' in very explicit ways, invited to surveille their children's behaviour and provided with guidance on how to do so. The opening page of all Life Education work books reads "KIDS, Why not get the adults at your home to help you learn why you're so special and unique" while the last page of each resource is headed "kids! Grab your adult!" followed by questions for adults to ask of their offspring. The APPLE study newsletter (University of Otago, 2005) invites parents to "help your child by joining in and signing off the postcards" in a virtual triathlon. Parents are invited to not only surveille the nutrition and exercise habits and behaviours of their children but to demonstrate their support by 'joining in'. On New Zealand's 'Get Kids' Active' internet site, hundreds of tips on how to engage children in physical activity are posted and in SPARC's new initiative, 'activate' provides a similarly exhaustive list on ways parents may ensure their children meet World Health Organisation targets of 30 minutes per day of sustained exercise.

The inaugural edition of 'Kids Life' – a New Zealand magazine with "a passion for the health and wellness of the world's children" (Greig, 2003, p.4) opens with the following warning:

Given the fast rise to obesity our children seem to be embarking on, we feel it is imperative that we as parents, educators and adult role models start educating ourselves – and our children – earlier" (p.4)

The journal is full with advice on what to do about children's eating and exercise habits. Phrases like "Monkey see monkey do" and "get your children moving by moving yourself" remind parents that they are role models for their children. An article in the 'parenting' section is headlined with "sneaky ways to help your children eat healthy" – In this piece, parents are encouraged to manipulate, deceive and trick family members into adopting different nutritional habits and desires. These magazines are just one of the avenues parents and educators have in popular culture for learning about what their children/students might need and how to provide it.

While there is nothing wrong with ‘joining in’ with a child’s activities, or endeavouring to make ‘health promoting’ behaviours ‘fun’, or educating oneself about the nutritional value of assorted foods, it is the narrowly framed sets of prescriptions parents are invited to join in with and the pedagogisation of the child/parent relationships that results we take issue with here. Eating and physical activity are so much a part of everyday family life, both behaviours being used in celebratory *and* function ways, yet in the context of neoliberal obesity discourses, physical activity *and* food become vehicles for achievement of purposes quite distinct from these ones. That is, food is something to be monitored and surveilled rather than enjoyed and a walk to the park an opportunity to burn off calories rather than chat with each other. This is not to say that one can’t enjoy food while also thinking about how ‘good’ it is for one’s health *or* that all attempts to monitor a child’s food or exercise practices necessarily lead to an undesirable parent-child relation. Rather, the point is that the sheer weight of the obesity discourse is such that it becomes very difficult to think about ordinary practices like eating and walking as *not* linked to the attainment of a healthy ‘ideal’ (whatever that ideal may be).

Concluding thoughts: Children as social actors?

Many of the health initiatives discussed above are ostensibly useful things. Many would ask what’s wrong with children ‘taking action to improve their own and others’ lifestyles, what’s wrong with children eating less fatty and sugary foods, replacing greasy chips with glistening lettuce leaves? Isn’t it great that schools are generating programmes and resources attuned to getting the message about healthy eating and exercise through? Indeed, in the current context, it is challenging to regard these practices and their perceived effects as anything but ‘good’. However, as we have endeavoured to demonstrate, together with positioning parents as culpable, generating surveillant relationships between parents and children, encouraging excessive levels of self monitoring and assessment, these kinds of imperatives *also* allow things to happen which in other social justice contexts would not or could not happen in schools. Inspecting personal lunchboxes, requiring that children regularly report on their everyday practices (like eating, drinking, sleeping, moving and feeling), measuring children’s girths and endeavouring to ‘scare’ children and adults into submitting to particular neo-liberal versions of prescriptions for a ‘healthy’ life are not ‘just’ practices. The persuasiveness of the obesity epidemic, in particular its ‘everyone everywhere is at risk’ message allows things to happen within communities that contradict the very strong social justice intent and ethos expressed at government level. In essence, the obesity phenomenon (or panic) allows one to disengage from other ways of thinking about children, young people, communities and cultures, because, as is the case with all other forms of wide scale panic, the fears associated with it give rise to otherwise unimaginable practices.

One of the most pernicious effects of a fear-based discourse around ‘fat’ is the dilution and distortion of content from some health and physical education curriculum practices in schools. In nutrition for example, instead of discussing what fat *does* in the body, a notion that ‘fat is bad’ is foregrounded. In physical education, the joy and pleasure of finding out how your body can work in ways that may be functional, aesthetic and/or performative (in the competitive sense) is replaced by a notion that bodies need shaping, training and ‘work’ to achieve an unachievable ideal (Evans & Davies, 2004). Well intentioned as they are, we suggest that many of the programmes and initiatives being introduced in the

name of alleviating the obesity epidemic, work intentionally, or otherwise, to subvert and impoverish existing health and/or physical education curricula.

The sheer volume and scope of resources being applied to schools provides children with a wealth of information and knowledge about their own and others' health, yet the nature of that information is such that it tends to close down rather than open up possibilities for young children to think critically and weigh up options for themselves relevant to their particular life circumstances. Indeed in the face of so much information presented with such certainty and in light of the often-simplistic prescriptions envisaged for change (i.e. balance outputs and inputs), critical pedagogy is reenvisioned as engaging students in a particularly circuitous route toward achievement of a unitary healthy 'ideal'. That is rather than being told what is 'good' for them students are 'facilitated' to understand this for themselves through enactment of a carefully staged and framed set of avowedly liberal practices. In this scenario critical thinking becomes yet another technique for getting students to come up with the 'right' answer rather than a genuine attempt to promote a transgressive, potentially socially just pedagogy geared toward celebrating a plurality of context-specific meanings about health and physical education (as purported in the document). Choosing 'skim milk' over 'full fat' or 'olive oil' over 'butter' become the 'right' answers to questions framed within such a constrained and sometimes outright misleading knowledge base.

What is clear from our prior research (Burrows, Wright and Jungersen-Smith, 2002; Burrows & Wright, 2004a, b; Wright & Burrows, 2004) is that children as young as eight years old can and do clearly articulate the health messages adults desire them to have and to hold – they 'know' what they are 'supposed' to think and do in relation to health producing behaviours. In one prior project we analyzed National Education Monitoring Project data derived from year 4 and year 8 New Zealand children's responses to questions about health and fitness. Across all socioeconomic indexes, ethnicity and gender groupings, children articulated very clear messages about what they could *do* to improve their health (see Burrows et al, 2001; Burrows & Wright, 2004a, b; Wright & Burrows, 2004). Eating right, drinking water and doing lots of deliberate exercise were the most commonly rehearsed prescriptions for achievement of a healthy self, with many children articulating in considerable detail the particular foods and kinds of exercise that should be undertaken (e.g. 12 glasses of water per day, 5 fruit and vegetables, 25 laps of the field). The prevalence of student responses implying that weighing and measuring selves before and after exercise was a route towards good health points to the connections between weight, size and health very young children are already able to draw. The guilt and self-monitoring that Atrens (2001) and others (e.g. Fine, 1988; Kehily, 2002) suggest accompany many health promotion imperatives was also clearly instantiated in many of the students' responses, as was a generalized antipathy toward 'fat'.

While official discourses around contemporary schooling and many of the initiatives discussed above, situate children as neoliberal subjects with the freedom to make informed decisions and choose how to act on the basis of these (both for themselves and in terms of transferring the knowledge to homes and communities), our analysis suggests this is delusional on two fronts. First, such a claim assumes that children are linked to their communities in particular ways, placing obligations on young people to be conduits for messages not of their own making. Secondly, what young children are mostly

provided with is a collection of 'facts' linked to the emotive messages of a moral panic around obesity (and other health risks like diabetes and heart disease). On the one hand, one could regard some of the practices discussed as empowering young people through giving them access to information, yet a social agent in the sense of being an 'active citizen' (Hall, Williamson & Coffey, 2000; James & James, 2004) requires an awareness of class, of culture, of the range of different interpretations of given phenomenon that are possible and desirable in given sociocultural and economic contexts. One of the unique things about the obesity phenomenon is that children's experiences and knowledge of it in both home *and* school contexts are likely to cohere, due to the sheer volume and consistency of information about it surfacing in so many different mediums. If children are to be active participants and negotiators of their social worlds then recognition of the constraints on that agency (and the potential activism it produces) resulting when adults in both home and school settings are encouraged to regard children as both potential victims and causes of an obesity epidemic seems crucial.

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