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Beyond body facism: the place for health education

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Chapter 17

As I was writing this chapter, I became involved in an email exchange following a colleague's posting of a link to a radio interview with several proponents or members of a new "global community" called the Quantified Self (QS)[i]. The exchange spoke immediately to the concern that has prompted many of the papers in this collection about the means by which individuals and populations can be governed, in the case of the QS, by technologies which allow a close monitoring and regulation of the body. Subscribers to the QS community use phone apps and other forms of technology—to measure and provide immediate feedback on the status of their bodies in relation to "health, fitness, weight and injuries" (transcript, ABC Radio National Interview, Feb 2013). For proponents, this is a way of "marrying technology with self-improvement" (ibid), of changing one's relation to the embodied self. Talking about how the QS started, Ernesto Ramirez makes this quite clear:

> And [the early proponents] saw that computing was becoming closer to our bodies—allowing us to see things in ways we were never able to see before. Especially through the use of sensors and personal technologies that were helping people track themselves. (ABC Radio National interview, Feb 2013)

Later in the interview, in response to a question that suggests people have been self-monitoring in sport for some time, Ramirez expands on the use of technology for self-monitoring:

> You're right, this is something that people have been doing even before there was the technology you know. But what was really, I think, the turning point with what we're seeing now is that it's becoming much easier to track. Say for instance you wanted to track your physical activity. You know, this has usually been done by people going to the gym, just writing down what they're doing, maybe keeping some notes in a notebook. But now, with the use of accelerometers, GPS sensors, heart rate monitors we're able to track those different pieces of information about our activity in a much easier way. (ABC Radio National interview, Feb 2013)

Our email responses to the posting point to the dilemma that faces us in contemplating this phenomenon and, for me, the complexity of body-focused practices related to health and indeed the field of health education itself. On the one hand, the potential for close regulation and self-monitoring immediately elicits the spectre of disciplinary power and neoliberal governmental technologies. The new phone apps provide the means to more closely regulate the body, to provide further and more finely tuned means of comparison with standards and norms. Indeed, Deborah Lupton's paper, "Critical Public Health",

demonstrates how governmental agencies such as those involved in health promotion are already looking to utilize apps to "change unhealthy lifestyle habits" (Lupton, 2012, p. 2). She provides the example of a study that uses mobile devices to monitor alcohol consumption amongst college students in order to "administer 'just-in-time' interventions to intercept unhealthy behaviours" (p. 2). In another example, David Rushkoff (2013) suggests in his book, *Present Shock,* that apps will provide the feedback necessary to make the next decision on how to act. It is easy to imagine a life which becomes impossible to live without knowing how many kilojoules have been consumed in the last meal and exactly how far it would be necessary to run, walk, or spend time in the gym to work it off.

On the other hand, for many people, mobile devices provide feedback that assists them, for example, to sleep better and to manage injury and pain. This raises the complex issue of the pleasure that people derive from being able to control their own health without reliance on medical experts; indeed the pleasure in "knowing" one's body, of being able to calculate improved capacity and ability. For Brian Pronger (2002), this dilemma is recognized in an understanding of the body as dynamic and at the conjunction of multiple force relations. For Pronger, the governing of the body (*pouvoir)* is never total, the possibility of pleasure always there to be brought into play, to present moments of freedom from regulation (*puissance*). However, the pleasure he describes is almost a metaphysical pleasure, the pleasure of losing oneself in movement. Can pleasure also be derived from external sources, from feelings of control? Pronger, following Foucault, would argue that these are the results of the internalization of desire, produced through pouvoir or the power of government and so producing body fascism. Fascism, in this sense, encompasses the "fascism in us all, in our heads and in our everyday behavior, the fascism that causes us to love power, to desire the very thing that dominates and exploits us" (Foucault, 1983, p. xiii).

From Pronger's perspective, pouvoir closes down possibilities of becoming, limits the possibilities of being and creates new desires in accordance with governmental aims. Medico-scientific knowledge about the body (such as that which seems to dominate QS, physical education and arguably health education) closes down other ways of knowing the body: "the paradigms of systems of knowledge determine what is seen and what becomes real" (Pronger, 2002, p. 117). This notion of internalized desire for the purposes of governing resonates with Rose's notion of "healthism" as a doctrine that links the "public objectives for the good health and good order of the social body with the desire of individuals for health and well-being" (Rose, 1999, p. 74).

Pronger's aim then becomes to track down and counter "all varieties of fascism" in order to "open up the possibilities of living outside of fascism" (Pronger, 2002, p. 112). To a very limited extent, this paper explores whether this is possible. Can a health education both in and out of schools, which is legitimated in terms of the serving the public good (health), operate outside of fascism/neoliberalism?

A health education beyond fascism: Take 1

Many of the papers in this collection have indeed tracked down and identified how the "fascism" of neoliberalism impacts on what is possible in health education. In this chapter I continue this theme, wrestling all the time with the conundrum of imagining a health education somehow distanced from its neoliberal context, when that context seeps, in so many ways, into our everyday lives.

I begin by pointing out that the papers in this collection continue a line of argument that can be mapped through several edited collections many of which include chapters by authors in this book. These earlier collections have been primarily, but not only, directed at physical education. The shift of focus to health education in this book, and by other writers, specifically signals a shift within the physical education field to acknowledge that, in a number of countries, health is now formally coupled with physical education in mandated curricula. This shift expands the focus of body technologies to include other areas that come under the scope of health education such as sexual health, mental health, drug and alcohol education. It more directly encompasses the notion of the young body at risk on all fronts.

What is similar, however, is the concern that physical education and health education as curriculum areas, which take the body as their focus, are well-placed to enact neoliberal governmental technologies. Looking back, it seems that many of the themes raised in these earlier books persist, in somewhat different theoretical guises, and some seem to have come full circle—through critical theory, feminism, poststructuralism/postmodernism to critical theory (see Fitzpatrick in this collection). The constant is the critique of normative practices and the frustration of searching for workable alternatives. Rereading Tinning's (2004, p. 220) concluding chapter in "Body Knowledge and Control", I was left wondering whether his question as to the possibility of spaces available for curricula and pedagogies that address "the social production of body" as the source of "postmodern ambivalence and neuroticism" has been answered. Or whether we have found more democratic approaches to schooling in which young people can become more active participants? In Walkerdine's (2009) commentary chapter "Biopolitics and the Obesity Epidemic", she asks similar questions: "how can critical intervention happen? What effectivity can it have?" Are we any closer to the answers?

The papers in this collection endeavour to contribute to the ongoing dialogue. Like most of the papers in the previous collections they adopt, as their starting point, a critical position, which takes health education as a productive site for "new public health agendas" under neoliberalism. For some, the focus is specifically on school-based health education; for others, the boundaries between various sites of health education are permeable so that corporate and governmental priorities leak into schools; other papers examine the pedagogical work of sites such as the media and the internet. As my contribution to this dialogue, in this last chapter I draw on my earlier work on biopedagogies (Wright, 2009) to explore the spaces for a health education beyond body fascism.

I take biopedagogies to combine Foucault's (Rabinow & Rose, 2006) concept of biopolitics with Lusted's (1986) notion of pedagogy, in order to understand health education as a relational cultural practice that contributes to our understanding and our desire to live a healthy life. Health education does not exist in policy, curriculum, or in classrooms but in the relations between these and, in the end, in the construction of knowledge and selves by the subject-learners. Hope can therefore be looked for in all or any of these sites, for the potential to disrupt the totalizing effect of neoliberal/fascist ways of knowing. Given the messiness and inconclusivity of this process (see Tinning in this collection) there is some cause for optimism.

The content: What is health education?

The notion of health education taken up in this collection reflects the range of possibilities for interpreting the term. Macdonald, Johnson, and Leow take some time to discuss its more various mainstream definitions in relation to public health and health promotion. In other chapters in this collection, it has been taken to be a term encompassing public or biopedagogies (Lupton) aimed at the populace in general or specific elements of the population judged to be at particular risk (Lupton, Dagkas), knowledge generated by social media (Sirna) and school-based health education (Leahy). Health education, in its broadest biopedagogical sense can thus include anything from the work of purposefully designed media campaigns to assessments and advice provided by medical and health professionals; it can include judgments and information provided by family members and friends and chance conversations in workplaces or the street—anywhere where health or the body become topics of conversation.

The dividing line between health education as a public pedagogy and school-based health education is increasingly becoming blurred, as multinational bodies produce health education resources for use in primary schools (see Powell and Gard & Vander Schee, this volume), government advertising programmes become resources for teaching about "risky" behaviours in relation to road safety, drug use and sexual behaviour and students use internet sites as sources of health knowledge both in the context of the school curriculum and to make important decisions about their bodies and lives. The boundaries are also blurred within schools—with the responsibility for encouraging children and young people to develop healthier lifestyles extending to *all* teachers not just those teaching health education. This can involve pressure on teachers to monitor their own behaviour (as healthy role models). It can take the form of measurement and reporting on children's health and capacities through standardized fitness tests, weighing and BMI calculations, calculating the caloric values of students' food intake (shades of the Quantified Self).

While, as Macdonald and her colleagues point out in their chapter, the relationship between health and schooling has a long history, it is relatively recently that health education has had a recognized teaching focus in schools. Lupton and others (Lupton, 1995; Peterson & Lupton, 1996; St Leger, 2006) have identified the late 1970s and early 1980s as times of intense health policy activity, which in turn, greatly influenced how health education was configured.

According to Leahy (2012), this surge of interest in health education in the 1970s can be understood as the

> result of a complex assemblage of shifting neo-liberal political agendas, emerging social movements concerned with the social distribution of health and inequity, shifting approaches to thinking about and managing education and a burgeoning academic field with its gaze firmly set on understanding, and changing, the health of populations. (Leahy, 2012, p. 21)

By the 1980s there were health education curricula in most Australian states and in New Zealand, mostly, but not always, coupled with physical education. As Kirk and Gray (1990) point out, school-based health education has not had those characteristics that enable it to stand alone in competition with other high-status subjects. The arguments for this are not always clear and several writers have questioned the appropriateness of this coupling. However, it is now enshrined in curricula in NZ and in each state and territory in Australia.

It is interesting that the most pessimistic comments about school health education seem to come from Australian and New Zealand writers where health education is coupled with physical education and is a mandatory component of the curriculum. In the UK, Personal, Social, Health and Economic Education (PSHE) stands alone but remains "a non-statutory subject" (Department for Education, 2013) After a review of the subject, the UK government chose to leave curriculum development up to schools rather than developing new standardized frameworks or programmes of study. The Minister of Education commented, "Teachers are best placed to understand the needs of their pupils and do not need additional central prescription" (Department of Health, 2013, p. 1). While the failure to make PSHE mandatory was met with considerable frustration by lobby groups, for all of the usual and contradictory reasons, this does present a different model of health education from that in Australia and New Zealand. It is not coupled with physical education and the PSHE professional association is very active in training teachers, producing resources and supporting curriculum development at the school level. There seems to be very little research at this point in time which examines PSHE more closely in terms of its pedagogy or effects.

So if we come back to the Australian and New Zealand situation, health education does have a mandated place in the curriculum in all states and is now further formalized by an Australian Curriculum: Health and Physical Education (HPE). Those who would advocate for a health education that is straightforwardly education *about* health rather than education *to enhance* health face a dilemma. The rationale for health education in the school curriculum is that it will contribute to a public good—that of enhancing children's and young people's health. Compared to the disciplinary knowledge and skills associated with literacy, mathematics and science, health education derives its disciplinary knowledge from across a range of disciplines. This suggests that one reasonable alternative is that it could be integrated into other learning areas—taught from other disciplinary bases. Indeed this is the case in some European countries. The investments by HPE in health education suggest this is not going to happen any time soon—rather the joining of the two seems to be becoming more

entrenched. In the Australian Curriculum (AC): HPE, while there are two strands—one named "Personal, social and community health" and the other, "Movement and physical activity", feedback from state education authorities requests as much direction about integrating the strands as possible.

The social view of health informing the New Zealand curriculum and current Australian state curricula seems rather muted in the new Australia Health and Physical Education Curriculum. Rather it has been replaced by the new concepts for these curricula of a strengths-based approach based on Antonovsky's salutogenic view of health (mentioned in references in a Draft Shape of the AC: HPE but not in any of the main text or any of the curriculum planning documents). In this collection, Quennerstedt and Öhman argue that a salutogenic approach does not take health solely as an individual issue but also "a socio-cultural one in which students' lives, experience, contexts and life histories are of the utmost importance". This aspect of a salutogenic approach seems, however, to be "lost in translation" (Leahy, 2012, p. 134) in the design of the AC: HPE. The continued emphasis on individual health with what seems to be an almost exclusive focus on enhancing students' health through informed decision-making persists. This assumes that all students are responsible and capable of improving their own health in the directions desired by the State. Despite the arguments put forward by Fitzpatrick and other exploring the possibility of a more critical health education, this seems an unlikely development in the current political contexts in Australia, New Zealand, United Kingdom, Canada and the United States. This is not to say that there are not spaces for a more socially critical approach. In the AC: HPE, there is scope for questioning "the taken-for-granted" and in the cross-curricular perspectives (Leahy, O'Flynn, & Wright, in press). But whether these are "picked up" depends very much on teachers' translation of the curriculum into classroom practice.

Teachers/ knowledge translators—enactors

What counts as "content" in health education is mediated, in schools, by teachers and, more broadly, by health workers, instructional designers, indeed anyone who is involved in translating health knowledge for educational/instructional purposes. In this section, however, it is more realistic to focus on how teachers as curriculum translators or enactors might become sources of hope in opening up possibilities for a health education that refuses neoliberal health imperatives.

Health education as a subject area asks a lot of teachers; it asks them to be knowledgeable about and teach across an enormous range of disparate areas. These expectations are multiplied by its coupling with physical education. It is not surprising, then, that for some teachers the simplest interpretation and the one most coherent with their subjectivities is to see health education as an extension of physical education and to base their teaching of the more problematic areas, such as sexual health, on the scientific-medical "facts" with which they feel comfortable. As Tinning points out in his chapter, this is some cause for concern; the dispositions and discursive histories of HPE teachers do not dispose them to question dominant healthism discourses.

On the other hand, health education has become more established as an area with its own learning outcomes and in some tertiary institutions more time is devoted to specific content areas. It also seems, if Leahy and McCuaig's research is at all indicative, that HE teacher educators in Australian universities regard "disrupting problematic understandings and practices" as a key task. The respondents in their study also talked about how difficult this was when they had so little time to teach a complex and multifaceted subject and had to compete for time and influence with studies dominated by human movement and exercise science. The HE teacher educators also spoke about how disrupting their students' understandings at times conflicted with their responsibility to assist students in teaching to curriculum outcomes and having sufficient content knowledge to survive in health education classrooms as beginning practitioners.

In research with secondary HPE preservice specialists, O'Flynn and I found that the HPE preservice teachers we interviewed took teaching HE very seriously. Although some of the preservice students we interviewed reported being in schools that they described as traditionally sport oriented, more described themselves as working with HPE teachers who drew on a strengths-based approach and who worked thematically and imaginatively with the curriculum. There was, however, little evidence that the preservice teachers or their supervising teachers brought a "critical" perspective to their teaching. Rather, their priorities were in engaging students through up-to-date resources and in using technology to assist pupils in acquiring health knowledge in order to make healthy decisions. I would argue, however, that their teaching practices would, for the most part, not have met the critical health education criteria listed by Colquhoun or Fitzpatrick (see Fitzpatrick's chapter in this collection). In part I would argue that this is largely because, by definition, particular ways of knowing are dominant because they are shared by most of the people most of the time and HPE teachers are generally part of the cultural mainstream. For most, their experience has rarely troubled this position. They have had little chance to develop what might be called a "sociological imagination" or the critical framework that some foundational education in sociology, philosophy or cultural studies might afford, or the experience of marginalization to enable them to move beyond the truths of scientific-medical "fact" and epidemiology. In addition, they are working with a curriculum that can be read as not challenging dominant ways of knowing, although it is ostensibly informed by a socio-cultural perspective. And finally, there is little incentive: their preparation time is taken up with finding resources, rather than reading or searching for a range of positions on a topic.

Pressures on teachers to maintain the status of health education as a "real" subject can also mean that teachers who are committed to the subject engage in performative practices of teaching and assessment that limit their capacity, and even desire, to develop content that responds to students' interests. Neoliberal imperatives thus work directly through forms of teaching practice that emphasise the transmission of authoritative knowledge to "unknowing" students, thereby emphasising efficiency and technique. This is illustrated in the following quotes from Ken Cliff's (2007) study of health education teaching. He

writes about how the desire for predicable outcomes shaped lesson planning for one of the teachers he worked with in his study.

> The most explicit effect [on lesson planning] of taking up performativity based discourses of expert practice was that the pedagogy selected for the unit was primarily teacher-directed in nature because such pedagogy was seen as efficient and the outcomes predictable. Complementing this effect is the finding that certain student-directed learning strategies were excluded from the lessons, or at least recommended against, because they were too time consuming and produced unpredictable outcomes. (Cliff, 2007, p. 128)

Further into his discussion he suggests that predictability can run counter to what constitutes "quality" teaching and the possibilities of a more socially critical practice:

> In planning the lessons, student-centred pedagogy and activities derived from student research were positioned as unpredictable and as not necessarily leading to the development of the "right knowledge." If, as work such as the Productive Pedagogies research (Hayes et al., 2006) has argued, such unpredictability is necessary if a teacher wishes to develop intellectual quality areas such as higher order thinking and the presentation of knowledge as problematic (p.42-43), then the exclusion of such pedagogy represents a considerable constraint on the development of a sociocultural perspective, where such a perspective involves students questioning assumptions, critically engaging with established knowledge and points of view, and developing considered arguments. (Cliff, 2007, p. 131)

As well as running counter to "quality" teaching, there are more practical problems with notions of the teacher as "knower" and the transmitter of "reliable" knowledge. Sources of health education knowledge are rapidly overflowing the possibilities of classroom instruction. As Sirna points out, the internet and social media provide the means to source health information, to test out opinions and indeed for students to produce new knowledge. In this context, the teacher as knower no longer becomes a credible position. Macdonald and her colleagues in their chapter argue the role of teachers in the future will be as "knowledge brokers", "guiding students' individualised learning, appraising resources, directing students to learning partners and partnerships and assessing their learning for certifications". Sin's (2008) defines knowledge brokers as "individuals or organizations that bridge the evidence and policy/practice divides" (p. 86).

Being a knowledge broker is clearly far from a simple matter. A short literature search suggests that at the moment the term is referenced primarily in the literature on universities and university courses, some including teacher education. What, then, does it take to be a knowledge broker? Is it a conduit to knowledge or does it involve some assessment of knowledge? What skills do teachers need and what does teacher education offer for potential knowledge brokers? Sirna in her chapter, for example, suggests that teachers need to be

familiar with, and engage with, social media in order to "appreciate the possibilities and ultimately create ways to support young people to be critical participators in these new social media spaces". Lupton (2012) argues that, in the context of new mobile digital devices (apps), (a critical) digital literacy should be part of "health literacy". She sees it as a way of shifting the power relations between health promoters and those whom they would target.

> An integral aspect of Web 2.0 technologies is the space they provide for audiences and consumers to engage with each other, to resist attempts to position them in certain ways, to challenge power relations: in short, to "talk back" to those who may be attempting to change their behaviours, both individually and collectively. (Lupton, 2012, p. 242)

This suggests that teachers will require a very sophisticated knowledge of how social media works and how knowledge is produced and exchanged. How does HE teacher education prepare teachers for this challenging task? Are they provided with some grounding in deconstruction, the ability to recognize and assess vested interests, ideologies and so on? It would seem that, to be a capable knowledge broker, these would be minimal capacities.

The learner

In an ubiquitous health education, everyone becomes the subject of health education—no-one is spared once they have language. Before birth and after, mothers are instructed in the measures they should take to ensure they give birth to a healthy child and their responsibility to carefully monitor the child post-birth to produce a "civilized self/citizen" one who is "rational, self-controlled and consciously seeking to achieve good health" (see Lupton in this collection). The small child, itself, is subject to the messages of children's TV (see (Welch, McMahon, & Wright, 2012) and adults' comments about a whole spectrum of "un/healthy" behaviours. From childhood the messages accumulate, governing every aspect of our health and lives, using a range of rational and affective devices to enhance compliance. In other words, everyone becomes the subject of health education pedagogy.

This is not say that everyone becomes an "ideal" subject. Indeed the stridency of media coverage about those who "fail" and the millions of dollars that go into health education and promotion programmes suggest that those whom health education would target are not necessarily compliant, nor are programmes hitting their mark. Several writers in this collection, for example, point to the dissonance between what happens in the name of health education both in and out of schools and in young people's worlds. Writing about young people's responses to programmes promoting responsible drinking, Kelly says young people do not see themselves as subjects of neoliberal discourse; such discourses do not account for the complexity of the pleasures and pains associated their use of alcohol. There also seems to be consensus amongst researchers in other areas of health education that school-based health education misses the point when it comes to what young people want to know and talk about. The following quote

from Allen's (2005) description of interviews with students about their experiences of sexuality education makes this very clear:

> Participants' suggestions provide a critique of current sexuality education provision that is clinical, de-eroticised and didactic. Young people's calls for content about emotions in relationships, teenage parenthood, abortion and how to make sexual activity pleasurable, offer insights into how they understand themselves as sexual subjects. Student responses position them as having the right to make their own decisions about sexual activity. These narratives also assert their right to access knowledge that will foster their engagement in relationships that are mutually physically and emotionally pleasurable. This positioning sits in conflict with the preferred non-sexual identity young people are offered by the official culture of many schools. (Allen, 2005, p. 43)

A constant lament from teachers (and preservice teachers) seems to be that, even when students "'know" the risk and the practices/behaviours to avoid these, they still engage in unhealthy eating practices, binge drinking, unprotected sex, and so on. It would seem that, despite a concerted effort of information provision and fear-mongering, health education is not particularly effective in changing behaviours; if this is its purpose, it is working with a particularly resistant population.

On the other hand, research with young people about their meanings of health and their bodies suggests that health education can have effects that can be damaging, that touch different children differently—"viscerally, emotionally and socially" (Burrows & Sinkinson). Certain health knowledge seems to stick for those people for whom it is going to be most dangerous. Burrows and Sinkinson argue that the preoccupation so many young people have with shaping their bodies to achieve a desired appearance—one not achievable for most of them—is unlikely to be a route to happiness, but rather promotes anxiety, shame and guilt. Health messages can pathologise whole groups of young people, for example, the Indigenous, poor, young people from ethnic minorities, and can reiterate health messages that bear little relation to their own values. More problematically, they can create anxieties because of the tension between school messages and home realities (see Burrows & Sinkinson, this volume).

In her paper in this collection, Sirna provides a fictional example of how a young woman researches information about breast augmentation via the internet and in particular testing out her ideas through her social networks. She points to the way social networking also allows participants to be knowledge producers. While she expresses some concern about young people's capacity to *critically* assess the information they are accessing and producing, from my point of view, this does suggest a different way of thinking about the learner that takes us beyond one who is simply subjected to a single line of information. It again points to the role of teachers as knowledge brokers who can suggest other sites with different points of view, engage in discussions with their students via wikis and Twitter. This would seem to be a more manageable space for discussion compared to a classroom with 30-plus students.

It is clear from the research in the areas of sexual health and drug education, that young people do want knowledge to help them think about their everyday decisions about eating, sexual relations, intimacy. The issue here is what counts as knowledge and are we being honest with students if we suggest that: i) as health educators we know the answers; and ii) that there are indeed simple answers to many of the questions they might have. Even if we are working with "knowledge" to assist in decision-making, the issue seems to be how to help students live with the notion of contested knowledge, ambivalence, and the contingency of knowledge.

A health education beyond body fascism: Take 2

There are two main issues taken up in this collection that I will focus on in the last section of this chapter. The first is whether it possible to have a health education that enhances young people's health but is not individualizing, "othering", morally judgmental, motivated by political or economic ends and instead is relevant, somatic, inclusive and responsive to young people's needs. The second is whether health education, specifically school-based health education, should *not* have as its main purpose improving health but to be *about* health—a critical health education that takes a disciplinary approach (see Fitzpatrick, this volume). In the first part of this section I will approach the first issue by drawing attention to a possible alternative way of thinking about health education that impacts on the possibilities of health education more widely and, indirectly, on school health education. This is the potential offered by the notion of a "counterpublic health", a concept developed by Kane Race[ii] author of *Pleasure consuming medicine: The queer politics of drugs* (2009), to address HIV education and drug education as public health spheres "where mainstream investment in a moral ideology compromises the ability to respond effectively to public health needs". Race does not eschew the need for health education, but argues that solutions need to create a shared concern rather than focusing on individual solutions and need to take place in contexts that open up possibilities for engagement and "collective reflexivity about certain risks and/or practices?"

> I began to picture the multiple public contexts that people have activated and engaged in order to undertake HIV education and prevention - the media, working groups, drag shows, conferences, blogs, sex venues, erotic performances, public forums, dance parties, research centres, internet sites, phone-lines, bars and service organizations. These spaces of collective activity have been crucial for the undertaking of HIV prevention. They've enabled us to transform our pleasures without denying or eliminating them.

While Race particularly targets groups where talking about their situation is likely to put them at risk of political intervention (e.g., drug users, sex workers), it is not that far removed to think of young people in a neoliberal context as those also vulnerable to moral judgments. It follows that a school-based health education programme may not be the most appropriate or even effective site for health education targeting specific groups deemed at-risk. Indeed, if moral

judgments underpin mainstream health education, and I would argue that they do (evidenced in judgments about body shape, eating and physical activity choices, sexual behaviors, (in)appropriate ways of dealing with emotions and so on), then many young people will find themselves positioned as "other", as the "bad" subjects of a discourse of healthism (see, for example, Dagkas, this volume). For these young people health education either becomes irrelevant or the source of damaging self-evaluations and positionings. An important tenet for a counterpublic health approach is offering young people the opportunity to talk about their health needs in their own words, before discussing and challenging those discourses which contribute to their health risks. Unlike the health education espoused by Race, there seems to be little space for school health education to take account of young people's expressions of their needs either locally (in school-based curriculum development) or in the development of the formal state curricula (young people were notably absent from the consultative process for the AC: HPE for example).

A counterpublic health approach would suggest that schools are perhaps not the most appropriate site for a health education designed to target practices that might be considered harmful for particular groups of young people. Kelly's paper in this collection would also suggest that this is the case. Young people need the opportunity to engage in conversations in real situations, to work with people they trust and respect, but as Kelly points out, local cultures and contexts can also take responsibility and encourage changes in practices (see for example, Kelly, Hickey, Cormack, and Harrison, 2011). Given that health education *is* taught in schools, what I draw from a counterpublic health perspective is that (like many of the authors in this collection) the planning for health education needs to more democratic and inclusive so that, at the local level, where arguably it is more possible, the translation of curriculum should happen in consultation with students, through whatever strategies work—from anonymous questions to a more elaborated democratic consultative process—if it is to succeed in enhancing young people's health.

School-based health education—a reality check

Involved as I am at the moment of writing this paper in the last stages of the AC: HPE, the frustration of imagining a school health education practice beyond fascism is particularly acute. Like others before me (e.g., Penney & Glover, 1998; Swabey & Penney, 2011) it has become evident that negotiations around curriculum making in a complex political context seem to privilege the most conservative elements. It brings home the point that HE has earned its place in the curriculum because it addresses a perceived social problem—the health and wellbeing of young people. It, of all subjects, most explicitly speaks to governing children and young people, to managing their "unruly bodies". Health education in this context means providing or facilitating students arriving at knowledge and skills which will enable healthy decision-making as defined by governing interests.

In this context HE in which the primary purpose is learning *about* health is unlikely to be able to justify its place in the curriculum. Educating about

health/studying health as "a political and social phenomenon" (Fitzpatrick, this volume) does not currently rate highly. As pointed out above, the review of PSHE in the UK underscores its marginal status in terms of government priorities. However, this is not to say that teaching *about* health it cannot be part of health education. As pointed out above, a counterpublic health is about addressing the contexts and discourses that put young people's health at risk in order to reduce that risk. It does not suggest denying pleasures but suggests a reflexive consideration of dominant discourses and contexts. This suggests a need to know about how health knowledge is constituted and how it works to position young people in relation to their health.

Learning about how health knowledge is constituted would also seem central to a (critical) health literacy. How is it possible to assess health knowledge without a framework in which to do so? Adding "critical" to health literacy or inquiry or any of the terms to which it is often affixed, from my perspective, implies recognizing: i) that all knowledge is constructed; and ii) that it not constructed from a neutral position but from ideological or discursive positions some of which are more apparent than others. In this sense all positions are political, including that argued for in this paper and in this book. Making this transparent seems an important starting point for any health education that is both for, and about, health. I finish with a quote from Nicholas Fox who, in arguing for a postmodern approach to health promotion, offers some suggestions that I would suggest are worth contemplating in thinking about health education in or out of schools. Following White (1991), Fox suggests acting with a *lightness of care*, which would entail:

> an emphasis which would act very locally, as opposed to more indiscriminate or totalizing interventions; programs which enable people to make active decisions about the lives they lead; a celebration of diversity in the target population, rather than a perspective which sees individuals as deviates from some norm of behavior; involvements which take advantage of spaces in routines and lives to explore new possibilities for activities and identity; and programs which do not detract from the humanity of those who are clients, for example, an overblown emphasis on "being healthy" as opposed to "becoming this or that". (Fox, 1998, p. 200)

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Notes

[i] ABC Radio National Interview. (10 February 2013). "Every breath I take…every move I make". Retrieved from ***http://www.abc.net.au/radionational/programs/bodysphere/the-quantified-self/4501462#transcript*** ***31/05/2013***

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