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**AN ANALYSIS OF  
HEALTH PROMOTION DISCOURSES  
IN THE CONTEXT OF  
NEW ZEALAND'S SCHOOL HEALTH CURRICULUM**

**A thesis presented in partial fulfilment of the  
requirements for the degree of**

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## **Abstract**

This thesis is concerned with the problem of a health *promotion* discourse within a health *education* curriculum. The problem is addressed through an analysis of health education and health promotion discourses which have been in use over the past half-century. It uses Michel Foucault's archaeological methodology to analyse the discourses of both the public health sector and the education (school) sector. It is argued that fifty years ago, both sectors used a health *education* discourse, but that since then, following policy directions from the World Health Organisation, the public health sector has developed and progressively favoured a health *promotion* discourse. It is only recently that New Zealand's education sector has begun to use a health promotion discourse in health curriculum documents. The thesis discusses some of the issues that surround this shift in discourse in schools.

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## Overview

When a national curriculum document is published in any area of learning (subject area), many things happen including the presentation of a 'way of talking' in that particular curriculum area. The focus of this thesis is on 'the way of talking' presented by the publication of Health and Physical Education in the New Zealand Curriculum (Ministry of Education, 1999)<sup>1</sup>. The language used by the curriculum writers has provided discursive resources which are then drawn upon in subsequent discussions: curriculum leaders, teacher educators and school advisers use the curriculum's discourse in professional development contexts; journalists and commentators use it publicly in the media; teachers use it when they talk to each other about the subject area; and schools present the new discourse in their communications with parents and students. Such widespread use of the curriculum's discourse ensures the language of the curriculum becomes the dominant way of talking in and about that curriculum area.

The curriculum is a combination of three earlier school syllabi: Health Education, Physical Education and Home Economics. The focus of this thesis is on the health education aspect of the new curriculum.

As with any new curriculum, the language used in the curriculum differentiates it from other curriculum documents, and earlier health education curriculum documents. My interest in the discourse of the curriculum is in the language of its 'underlying concepts'<sup>2</sup> - or its theoretical and philosophical underpinnings. Of particular interest to me is the underlying concept of health promotion. This interest stems from my work over the past seventeen years working as a health educator and health promoter in both the public health, and education sectors. With a longstanding interest in the philosophy of language I am interested in the language of the curriculum, especially the use of the term 'health promotion' within the document. My observation over the years has been that a health promotion discourse has been developed and used by the public health sector, and has only

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<sup>1</sup> From here on referred to as the curriculum.

<sup>2</sup> See Chapter Three for a detailed discussion of the underlying concepts: Hauora, Health Promotion, Socio-ecological approach, and Attitudes and Values.

recently been introduced into the discourses available to teachers. The health education curriculum is a key discursive resource for teachers, enabling them to hear a 'way of talking', and providing an opportunity for them to begin to practise and use health promotion discourses. This thesis critiques the health promotion discourse of the curriculum, and, through the methodology of the French philosopher Michel Foucault, explores some of the historical contingencies that allowed the discourse to become such a key 'underlying concept' of the curriculum.

My research questions stem from this interest in health promotion discourse, and from the curious situation where the (older) term health education is used in the title of the curriculum, but is neither defined nor used within the curriculum itself. Instead, the related (newer, public health) term health promotion is widely used throughout the document. Foucault talks of 'rare' events, where there are dramatic changes in discursive formation. Perhaps this is an example of one such shift or change in discursive formation where an (earlier) health education discourse becomes substituted by a (newer) health promotion discourse?

The first research questions are general questions that come from my observations (above) of the use of the term health promotion in the curriculum. These questions can be expressed as "Have the two sectors (Public Health and Education) used different discourses? Has health education discourse been the discourse of the education sector, and health promotion discourse the discourse of public health?"; and if so "How did the public health discourse of health promotion come to be a key discourse in a health education curriculum?" Following from these general questions I am interested in the following, more specific questions: "Are there discursive rules that govern the use of these discourses? and if so, what are they?"; and following this question, "Is the discourse of health promotion in the (education sector) curriculum used according to the discursive rules that have governed its (public health) use?"; and "Which (health education or health promotion) discourse, at any given period, came to predominate, with whom, and how?" A final question asks "Is the curriculum discourse able to be used as a tool by any particular political ideology to gain or maintain power and dominance?" It is these questions that I will attempt to address in this thesis.

A method for addressing these questions presents itself through the work of Foucault. His archaeological method provides both a 'historical' and an analytical analysis of discourse, and promises to help identify the rules that govern the use of a discourse, in this case the discourses of health education and health promotion. His genealogical (or critical) method adds additional analytical power, as well as providing ways of approaching and addressing the final question.

Given this, Section One begins with a detailed overview of the (broadly postmodern) work and methodology of Foucault (Chapter One). Starting in this way with a discussion of methodology may be unconventional, but it does allow all subsequent chapters to be written in reference to Foucault, his methods and his ideas. Foucault's methods allow critical analysis of particular discourses and can be applied to the discourses in the curriculum document. However, as I hope will become apparent, Foucault's methods do not examine discourses in isolation. Discourses are not separated out from wider contexts and conditions. Instead, his methods weave contexts and conditions into the very discussion and analysis of discourse. For that reason, my starting point must be Foucault, with the rest of the thesis written in the light of this chapter, and with wider contexts and conditions addressed in each subsequent chapter. Chapter One, then, sets out a framework for the subsequent examination and analysis of health education and health promotion discourses. The main objective of the chapter is to tease out Foucault's methodology in such a way that I am able to apply it throughout the thesis, as I attempt to answer my research questions. To do this, I will review in some detail, Foucault's archaeological and (to a lesser extent) genealogical methods, and indicate how his later shift in focus to techniques of the self might be approached and used to help answer my final research question.

In the process of constructing a Foucauldian framework, I refer to many epistemological concepts and ideas. Epistemology is about knowledge. The scope of epistemology is defined by questions about how knowledge is generated, and what counts as knowledge, how we gain our knowledge, and which knowledge counts as truth. How Foucault approached knowledge and truth in his writings is discussed in Chapter One. However, to help put his writings into context, I use Chapter Two to discuss in detail the epistemological underpinnings that are at the base of the Foucauldian position. Because

I have chosen to use Foucault's methods for the analysis of health education and health promotion discourses, this thesis falls firmly within a social constructionist epistemology. The story I tell in this thesis relies on a clear and early elucidation of this social constructionist epistemology. This is not an easy task, as most of us are unquestioningly embedded within a positivist way of thinking that makes it extremely difficult to understand a social constructionist epistemology. I attempt to explain the positivist way of thinking, how it has shaped and influenced the way in which we see the world, and how it has created a powerful intellectual legacy. For this reason I spend some time discussing positivism and outlining associated ideas, especially neo-liberalism, an ideology that has achieved wide political currency in New Zealand over the past two decades. The exploration of social constructionism in Chapter Two supports an understanding of Foucault's writing and method.

In Section Two, using Foucault's analytical methodology of archaeology, and to a lesser extent his methodology of genealogy, I explore the discourse of the curriculum, and analyse the discursive field(s) of health education and health promotion alongside the social and political conditions that provide contexts for these discourses to be used.

The existence of the two different terms 'health education' and 'health promotion' suggests that they have developed to do different discursive work. An archaeology of the discourses of health education and health promotion involves a detailed analysis of their use over time. However, this is no easy task, as their histories track side by side and intertwine for much of the twentieth century, making it difficult to identify the unity of each discourse. McHoul & Grace (1993) suggest that discourses can be "quite distinct from one another as well as from earlier and later forms of 'themselves' which may or may not have the same names" (p.31). They point out that forms and rules "are discontinuous. But they can also overlap and intersect as they change historically" (ibid. p.31). This overlapping and intersecting may have led to the confused and blurred use of the terms health education and health promotion in the curriculum. For instance, many landmark theoretical and practical publications (Green, et.al., 1980; Kemm & Close, 1995; Glanz, et.al., 1997) discuss both health education and health promotion under the title of one. In Ewles and Simnett's (1985) guide to health education titled *Promoting Health: A practical Guide to Health*

Education the focus is on health education, but the idea of promoting health is used prominently in the title. The authors draw attention to a confusion which arises from the use of the term 'health promotion':

This has been used more frequently in the last few years, and indeed some Health Authorities now employ Health Promotion Officers. Often, "health promotion" is used as an umbrella term which includes traditional health education, but sometimes it is used in more specific ways. It may refer to the marketing / advertising aspects of health education, or to the political aspects of lobbying for changes in health policy or legislation, or to changing health policies at local level. Finally, it is sometimes used to refer to the emphasis on positive health, as opposed to the negatively-flavoured prevention of ill-health (p.29).

Glanz et.al. (1997) note the observation made by Breckon et.al. (1994) that the terms health education and health promotion are often used interchangeably. I agree with Glanz et.al. that the two terms are "closely related, closely linked and overlapping and share a common historical and philosophical foundation"(p.9). However, unlike Glanz et.al, I do not believe that health education and health promotion are too closely related to be able to distinguish between them. Neither do I agree with Ewles & Simnett (1985) that the use of term health promotion is in itself confusing. This thesis rests on the assumption that there are different rules that govern the use of health education and health promotion discourses, even though they share much of the same historical and conceptual ground. These rules, identified through an archaeological analysis, "define discourses in their specificity" (Foucault, 1972: 139).

If a person had never heard of the terms health education nor health promotion it could be assumed that they had not been exposed to the health education or health promotion archive<sup>3</sup>. They would not have been involved in, nor heard, the wider discourses where the terms might be used. To learn how to use the terms appropriately, so that meaningful

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<sup>3</sup> For an explanation of this Foucauldian term, see Chapter One.

conversations can be achieved with others, a person would need to be exposed to the discourses, and practice using them according to the rules that govern their use.

Drawing upon a selected health education and health promotion archive and by following the suggestion of Sarup (1993) I will begin with recent health education and health promotion discourses and go backward in time in an attempt to locate and identify differences. Because archaeology is 'inherently interdiscursive' (Ritzer, 1997) I will be looking "for the tangle of contradictions and analogies that make up one discourse in contrast to others" (p.42), and looking for regularities and irregularities by examining the two discourses simultaneously throughout these chapters.

My approach is to use archaeology to analyse a selection of 'well-thumbed' text books from the health education and health promotion archive. This analysis systematically describes the titles of these texts and articles, definitions of health education and health promotion within them, key theories, and discussions by their authors about what health education and health promotion are. This systematic description is undertaken in order to demonstrate the unity of each discourse. I discuss how the unity of a discourse is defined by the rules and practices that allow (or disallow) certain things to be said. The unity of a discourse is not dependent upon the human subject or the author as it tends to do in a history of ideas. Using the archaeological method I am reminded that my interest will not be in who might have said something, but rather how it was possible that it was said at all. The overall aim of this archaeological analysis is therefore to define the rules and practices that allow certain discourses to become either health education or health promotion discourses.

When Foucault undertook archaeological analysis, he would use numerous quotes from the archive, creating a lamination effect. As I move from the present backwards in time, I use quotes liberally to allow the archive to speak for itself, while commenting on the chosen extracts, and seeking to find the rules that govern the use of the health education and health promotion discourse in each. This lamination technique that allows discourses to speak for themselves, is one I will use throughout the thesis.

While the archaeological method allows a detailed discursive analysis, it falls short of addressing the social and political conditions and contexts within which a discourse is being used. During the course of his writing career, Foucault became frustrated with the limitations of his (earlier) archaeological method. Likewise, as I embarked on an archaeological analysis I found that, on its own, it seemed somehow cut off from the real world, and raised as many questions as it answered. Therefore, I found a combination of Foucault's later genealogical method with the archaeological method useful in linking discourses with the real world. Genealogy provides a powerful methodology for making sense of the discourse within wider social and political conditions and contexts. Weaving a genealogical analysis allows a critique not possible by an archaeology on its own.

Foucault's approach to history forces us to look for 'historical contingencies' (Kendall & Wickham (1999), not origins and causes. This means that when we are confronted with an event, we must resist the urge to try and trace its beginnings. An event is not the necessary outcome of other, previous [causal] events, but is instead only "one possible result of a whole series of complex relations between other events" (p.5). This places the onus on the analyst to be constantly creative and open to possibilities - nothing is able to be taken for granted.

While resisting this urge to find historical causes, Foucault does propose that knowledge is much more a matter of the social, historical and political conditions under which statements come to count as true or false (McHoul & Grace, 1993; Loveridge, 1999). Truth, it seems, is contextual, changeable, and plural. Foucault does not want us to ignore the relationship between discourses and technical, economic, social and political events. In order to come to an understanding of the rules that make certain things possible to be said, we need to gain an understanding of the conditions that make them possible. Section One, especially Chapter Two, explores philosophical and intellectual conditions whilst Section Two analyses some of the relationships between health education and health promotion discourses, and key events and power relations that were occurring in the context of health promotion discourse during the timeframe chosen for analysis. This exploration of some of the conditions that have made health promotion discourses possible to be said is done in several ways. I use Foucault's methods to guide my exploration of the conditions

surrounding the emergence of contemporary health promotion discourse. 'Surfaces of emergence' (see Chapter One) are identified and described. As well, I describe those institutions which have acquired an authoritative role in delimiting the range and existence of health education and health promotion discourses. In doing so, I try to resist the urge to place events within grand explanatory systems and linear processes, and instead try to acknowledge the fragility of historical forms. I steer away from emphasising great moments and important people ('authors of power') and concentrate instead on the 'field of power'. And because power is comprised of "instruments for the formation and recording of knowledge (registers and archives), methods of observation, techniques of registration, procedures for investigation, apparatuses of control and so forth" (McHoul & Grace, 1993:22). I look carefully for those instruments, records, methods, techniques, procedures and apparatuses.

Foucault's insists that the analyst selects a problem rather than an historical period for investigation. It is very seductive to choose a period of history where health promotion discourse seemed to emerge. By including a study and description of what was happening socially, politically and educationally in New Zealand and internationally at that time, it is equally seductive to make the (non-Foucauldian) assumption that these conditions influenced or caused the new discourse. This standard structuralist move is, however, anathema to Foucault. And the challenge to select a problem, not a historical period has posed an organisational dilemma for me - how do I present the data and analysis in such a way that it is true to Foucault's guidelines, but is also manageable and understandable. For this reason, I have chosen to break the archive under analysis into three chapters, each picking up the discursive story at an ever earlier time. (The alternative was to have one very large chapter covering the entire health education and health promotion archive!) Breaking the archive in this way, Chapter Three focusses upon the discourse of the current health education curriculum (1999); Chapter Four on a selected recent archive back to the mid 1980s; and Chapter Five explores an archive from the early 1980s back to the middle and early twentieth century. The problem ever before me, is the existence of a health promotion discourse within a health education curriculum.

Throughout the three chapters I attempt to keep the problem and research questions to the forefront. What I will be doing in fact, will be exploring the idea of 'discursive domination'. Lupton (1997) has expressed this Foucauldian idea by asking what are the conditions where one discourse 'secures another within its bounds'? (McHoul and Grace, 1993). Throughout these chapters I attempt to address the idea that discourse is dangerous. I will be looking to see whether or not health promotion discourses became appropriated by those 'in positions of power, either to bolster their own power, or to silence those discourses that they consider[ed] to be a threat to their authority' (Ritzer, 1997). I attempt to explore those techniques and the technologies that are derived from health education and health promotion knowledge, and how they are used by institutions to exert (normalising) power over people. I ask whether health promotion discourse and knowledge is being used as a 'disciplinary technology' to create docile subjects, using people, transforming and improving them, and I examine the methods, practices and techniques by which official discourses go about this process of normalisation (McHoul & Grace, 1993).

The archaeological method drives the direction of my analysis. In Chapters Three, Four and Five, I proceed backwards in time until the discourses under analysis sound curiously quaint and out-dated. Then, in Chapter Six, I proceed forward again, tracing the changes and shifts in discursive formation that have been detected in health education curriculum documents in New Zealand. This analysis should, according to Foucault, make the older discourses and practices seem negative in relation to the present. Discourses which have been substituted by others will seem old-fashioned and out-of-place in relation to the current, favoured discursive formation. The process should "show how that-which-is has not always been" (Foucault, 1990:37), suggesting that the process explodes the 'rationality' of current, taken for granted discourses and phenomena (Sarup, 1993). Weaving a genealogy through the chapters of this discursive analysis provides a tapestry of contingencies that help to clarify shifts in discursive formation.

Throughout my story, I will attempt to retain a reflexive and critical stance to the shifting discourses in health education and health promotion while acknowledging my own involvement in the field. I am, and have been a 'player' in this discursive story during this time. This has, I believe, allowed me a unique position in the analysis of the discourse. My

partiality, bias and presence is openly acknowledged. It inevitably forms a context for the analysis.

## **SECTION ONE**

### **Methodology and Epistemology**

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This section sets the scene for the later discourse analysis by taking the reader on a journey that eventually arrives at the archive under analysis (Section Two). Chapter One reviews the philosophy of Michel Foucault and his analytical methodology - the methodology that I have chosen to use in the analysis. Chapter Two explores epistemological positions in such a way that Foucault can be better understood. I draw upon this understanding of Foucault's epistemological position in the writing of this thesis.



# Chapter One

## Foucault: a methodological framework

Many writers have attempted to summarise and comment upon the work of Foucault. Most indicate that his work is difficult, dense, provocative, and subject to multiple interpretations. Ritzer (1997) adds that Foucault is 'purposely elusive' as well as changing and shifting over the course of his writing career. During his career, Foucault's writing changed and shifted, going through three major overlapping phases. In his early writings<sup>4</sup> he did what he called an 'archaeology of knowledge'. This phase set the groundwork which subsequently allowed a shift towards a 'genealogy of power and knowledge'. Finally, in his later work until his death in 1984 another change occurred which raised a concern for the 'techniques of the self'. Each phase provides methods for analysing text and discourse. Rabinow (1997) takes a similar view regarding the phases of Foucault's writing, noting that "Foucault divided his work on the history of systems of thought into three interrelated parts, the re-examination of knowledge, the conditions of knowledge, and the knowing subject" (p.xi).

### Archaeology of knowledge

Foucault's early (archaeological) work sought to find the rules which govern the use of particular discourses. Before looking at what Foucault meant by discourse, I have found it useful to think of his archaeology of knowledge as different from, and critical of, a history of knowledge. Instead, I lean towards McHoul & Grace's (1993) description of archaeology as a counterhistory of knowledge.

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Loosely, the three phases of Foucault's writing fall into the decades of the 1960's, 70's and 80's.

### ***Foucault's approach to history***

One entry-point into Foucault's early work is through history. As I will explain and discuss in Chapter Two, history has been seen by some as continuous, progressive and cumulative, progressing from stage to stage, getting closer and closer to the truth, guided by underlying principles which remain essential and fixed (McHoul & Grace, 1993). Foucault, however, saw history quite differently from this structuralist<sup>5</sup> view. For Foucault, history (or archaeology) is discontinuous. "It does not proceed, in slow progression, from the confused field of opinion to the uniqueness of the system or the definitive stability of science" (Foucault, 1972:139). History is not seamless and rational (McHoul & Grace) nor is it a search for underlying structures or a concern for origins (Ritzer, 1997:41). Kendall & Wickham suggest that by not looking for causes of historical events, we are forced to look for historical contingencies. They explain this Foucauldian idea in the following way: "When we describe an historical event as contingent, what we mean is that the emergence of that event was not necessary, but was one possible result of a whole series of complex relations between other events"(1999:5).

Foucault's historical method, or as he preferred to call it, archaeology, focussed on bodies of knowledge which exist at given historical moments, particularly those of the human sciences. He looked at these bodies of knowledge (discourses), not with a structuralist's eye for trying to find continuity, underlying principles or origins, but rather with the aim of coming to an understanding of the unity of a particular discourse. He was interested to understand how it is that particular bodies of knowledge 'hang together', what rules govern the use of statements within that body of knowledge.

As I have indicated, archaeology is not to be confused with the history of ideas. Unlike the history of ideas, archaeology "is not an interpretative discipline: it does not seek another, better-hidden discourse" (Foucault, 1972:139). Foucault is not interested in underlying structures: archaeology does not attempt to uncover people's thoughts or intentions and motivations. Nor does it focus on "representations, images, themes, and

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<sup>5</sup> For a discussion of structuralism, see Chapter Two.

preoccupations that are concealed or revealed in discourses” (ibid.:138). In addition, in the spirit of postmodernism<sup>6</sup>, Foucault rejects “any form of global theorizing (sic). He wants to avoid totalizing (sic) forms of analysis and is critical of systematicity (sic)” (Sarup, 1993:58).

Archaeology is ‘discontinuous’ in the sense that it “does not seek to rediscover the continuous, insensible transition that relates discourses, on a gentle slope, to what precedes them, surrounds them, or follows them. It does not await the moment when, on the basis of what they were not yet, they became what they are; nor the moment when, the solidity of their figure crumbling away, they will gradually lose their identity” (Foucault, 1972:139). Rather, Foucault’s method uses history as a way of “diagnosing the present” (Kendall & Wickham, 1999:4). Foucault’s interest is not so much on the changing nature of discourse, its sequence, and its succession. Rather, “archaeology is willing to acknowledge and study the changes, ruptures, discontinuities, and sudden redistributions that characterize the history of discourse. In fact, the substitution of one discursive formation for another, while rare, is of the utmost importance, and only an archaeology of knowledge can deal adequately with such a dramatic change” (Ritzer, 1997:42).

Another way of understanding Foucault’s approach to history is one suggested by Kendall & Wickham (1999) - to select a problem rather than an historical period for investigation. In the context of this thesis there are two problems. The first can be expressed by the question, ‘Is a health promotion discourse the dominant discourse of the Health & Physical Education in the NZ Curriculum (Ministry of Education, 1999)?’ and the second by asking ‘How did the discourse of health promotion come to be a discourse in the curriculum?’ Another way of expressing these problems is to ask how health promotion comes to be a ‘Key Underlying Concept’<sup>7</sup> in a health education curriculum?’

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<sup>6</sup> Postmodernism is discussed in Chapter Two.

<sup>7</sup> The curriculum identifies four Key Underlying Concepts: Hauora, Well-being, Health Promotion and a Socio-Ecological perspective.

### ***Foucault's approach to discourse***

The goal of archaeology is to “define discourses in their specificity”(Foucault, 1972:139); archaeology “is the systematic description of a discourse-object” (ibid.:140). My task will be to systematically describe the discourses of health education and health promotion<sup>8</sup>, demonstrating the unity of each discourse. The unity of a discourse is defined by the rules and practices that allow (or disallow) certain things to be said and certain functions to be done. The unity of a discourse is not dependent upon the human subject or the author as it tends to do in a history of ideas. Using the archaeological method I will not be interested in who might have said something, but rather how it was possible that it was said at all? As I said in the Overview, this inevitably means an analysis of power relations that allow certain things to be said, and other things to remain unsaid.

So, for Foucault, what is a discourse? Firstly, it is argued (Burchell et.al., 1991; McHoul & Grace, 1993; Olssen, 1999) that Foucault's thinking in relation to discourse changed over time. Discourse is ‘things said’, or statements, “tied to an historical context and capable of repetition” (Olssen, 1999). In *The Archaeology of Knowledge* Foucault discusses divisions, groupings and genres that produce their own discourses governed by their own rules:

In any case, these divisions - whether our own, or those contemporary with the discourse under examination - are always themselves reflexive categories, principles of classification, normative rules, institutionalized (sic) types: they, in turn, are facts of discourse that deserve to be analysed beside others; of course, they also have complex relations with each other, but they are not intrinsic, autochthonous, and universally recognizable (sic) characteristics (1999:22).

He goes on to talk of the “field of discourse” (ibid.:26), where various forms of discourse exist and interact at a certain point of time, in a certain place. I find Hall &

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<sup>8</sup> For the analysis of the discourses of health education and health promotion see Chapters Three, Four and Five.

Gieben's (1992) discussion on discourse helpful here. They define discourse as "a group of statements which provide a language for talking about...a particular kind of knowledge about a topic" (p.291). As I indicated in my opening words in the Overview, the Curriculum is a discourse: it can be seen as a group of statements (within the confines of, say, a book), which provide a language for talking about health education and health promotion. For Foucault, statements should be thought of as functions rather than as grammatical structures. As a function, a statement is analysed according to the practice in which it is used, the conditions of use, the rules that govern it, and the field in which it operates. The discourse in a curriculum document is functional. It is used by teachers within the context of educational programmes in schools, becoming an 'action' document for teachers and students. As well, it functions as a key professional development tool for teachers by the Ministry of Education and is actively used within a wider education / public health field.

There are many different ways in which statements can be made about a topic. How statements are made defines the discourse being used as well as constructing the topic in a certain way. In this sense, discourse is about "the production of knowledge through language" (Hall & Gieben, 1992:291) but, as Foucault prefers, discursive practices are those practices that systematically form the objects of which they speak.

Following on from this, another aspect of Foucauldian discourse is the idea that each particular discourse constructs its own position, and from that construction, makes sense only to itself. In many respects this explains how people using different discourses when talking about a particular topic, seem to talk past each other (Metge, 1987), or seem not to understand what each other means. As I will propose later, teacher health educators and public health health educators working in schools both talk about health education and health promotion, but use different discourses. On occasions this leads to misunderstandings between teachers and public health workers, who fail to construct health education in the same way (Tuffin, et.al., 2001). Clearly, as in the example of teachers and public health workers working in schools, people who use one discourse do speak to people who use another discourse. In this way discourses draw on elements from other discourses, incorporating them into their own discursive formation. In a

similar way, “traces of past discourses remain embedded in more recent discourses” (Hall & Gieben, 1992:292). In my analysis I am interested in finding such ‘traces’, such as traces of health sector health education / promotion discourse embedded within education sector health education curriculum discourse; or past health education discourses remaining in the discourse of the new curriculum.

Finally Foucault’s approach to discourse is a critical one. It focuses on a “counter-reading of historical and social conditions and offers possibilities for social critique and renewal” (McHoul & Grace, 1993:27). Later in my discussion of genealogy, the strength of Foucault’s critique will become more apparent. In this ‘middle’ or genealogical period, it becomes evident that discourses are ‘a product of social factors of power and practices’ (Holloway, 1983). In this sense, discourses cannot be seen as harmless or innocent. Sarup (1993) introduces the idea of a “battle of discourses through discourses” (p.65), which leads to the idea expressed well by Lupton’s (1997) term ‘discursive domination’. Such domination can be seen to occur when one discourse - say, a scientific one - tries to interpret another discourse, using its own discourse to do so, or attempts to “secure another within its bounds” (McHoul & Grace:23). This process of interpretation, leading to capture, is the hallmark of discursive domination<sup>9</sup>.

### ***Foucault’s archaeological method***

Various writers have attempted to clarify the (archaeological) method that a researcher might use, following such a position (above). Most are clear that Foucault is concerned with the question, what set of rules permit certain statements to be made (or unable to be made)? (Sarup, 1993; Ritzer, 1997). In addition, given that the archaeologist is investigating a problem (not a period of history), it is “crucial that we allow our investigations of a problem to surprise us. Foucault’s methods involve the generation of surprising stories”(Kendall & Wickham, 1999:22).

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<sup>9</sup> This aspect of Foucauldian analysis will be discussed in more depth in the following section on Genealogy

One writer who has attempted to clarify Foucault's archaeological method is Sarup (1993) who compares Foucault's method with that of the historian. But unlike the historian "who traces a line of inevitability, Foucault breaks off the past from the present and, by demonstrating the foreignness of the past, relativizes (sic) and undercuts the legitimacy of the present" (p.58). Sarup suggests that the Foucauldian analyst "begins with the present and goes backward in time until a difference is located. Then s/he proceeds forward again, tracing the transformation and taking care to preserve the discontinuities as well as the connections" (p.58). Following Sarup's suggestion, the method (in the context of the discourses in the Curriculum) would be to describe health education and promotion discourses used in the curriculum looking at instances of these discourses in the text, and moving systematically back through earlier health education curriculum texts until a difference is detected. Then the same ground would be recovered (from that point back to the present), faithfully tracing the changes and shifts in discursive formation that are detected. At this point the older discourses and practices would be "explored in such a way that their negativity in relation to the present explodes the 'rationality' of phenomena that are taken for granted" (p.58). Discourses which have been substituted by others, sound old-fashioned, quaint, out-of-place. They can even seem to be saying the opposite of what is currently being said, or appear 'negative' when compared with the current, favoured discursive formation. Hence the importance of finding the rules that made it once possible for the older discourse to have been dominant and favoured, and to understand the new rules that have allowed the current discourse to be perceived as so rational, so 'right'.

Kendall and Wickham (1999) suggest that if we are to get the most from Foucault's archaeological method, we must "ensure that we do not allow this history to stop, do not allow it to settle on a patch of imagined sensibleness in the field of strangeness" (p.4). As a statement of postmodern epistemology (see Chapter Two for a detailed discussion of epistemology and postmodernism, a position that I argue is at the heart of Foucault's methodology), this is as clear an enunciation of the shifting truths that occur when discursive formations are substituted for others. An investigation of contemporary discourses puts them in their historical position:

They are relativised or pluralised so that they no longer seem to have unique access to the truth. Truth becomes a function of what can be said, written or thought. And Foucault's project becomes one of exposing the historical specificity - the sheer fact that things could have been otherwise - of what we seem to know today with such certainty." (Foucault, cited in McHoul & Grace, 1993:33).

Foucault (1990) believed that the things that seem most obvious to us are always formed through chance and unexpected encounters, during a 'precarious and fragile history'.

Another way of clarifying this idea is through an understanding of Foucault's term 'archive'. An archive is not a museum collection, nor is it the same as the historian's collection of texts and materials, historical documents or transcribed conversations which have, by chance, survived into the present. Instead it is "the form of organisation of the parts of a discourse (its statements)" (McHoul & Grace, 1993:30), meaning the "set of rules which at a given period and for a definite society defined the limits and the forms of expressibility" (Foucault, 1978, cited in McHoul & Grace:32).

The archive is first the law of what can be said, the system that governs the appearance of statements as unique events...it is that which, at the very root of the statement-event, and in that which embodies it, defines at the outset the system of its enunciability (Foucault, 1972:129).

These forms or rules "are quite distinct from one another as well as from earlier and later forms of 'themselves' which may or may not have the same names. They are discontinuous. But they can also overlap and intersect as they change historically" (McHoul & Grace, 1993:31).

Foucault is interested in identifying the regularities and irregularities that exist within discourse. Regularities are traced to several kinds of relationships - relations between statements, between groups of statement, and the relations between these statements and various events - technical, economic, social and political. Therefore a key aspect of

defining the rules that make certain things possible to be said is an understanding of the conditions that make them possible. This aspect of Foucault's methodology is better explained by 'genealogy' (see following discussion). In this regard, in Section Two I weave a genealogy into the archaeological analysis by exploring some of the social and political conditions extant over the period of time when the curriculum was being developed. I will argue that conditions within the health and education sectors during recent decades have made certain discourses possible to be said, while others have become 'difficult' or less acceptable to enunciate.

Irregularities are examined by describing contradictions in discourses. "Archaeology describes the different spaces of dissension" (Foucault, 1972:152). When archaeologists examine contradictions, they look at "their different types, the different levels at which they occur and can be mapped, and the various functions they can perform" (Ritzer, 1997:41). By looking for regularities and irregularities, the archaeologist must always be examining two or more discourses simultaneously. Archaeology is "inherently comparative...It looks for the tangle of contradictions and analogies that make up one discourse in contrast to others" (p. 42).

Yet another attempt to clarify Foucault's archaeological method is offered by Kendall and Wickham (1999). They agree with Ritzer (1997) that one of the key concerns in archaeological analysis is the description of differences, transformation, continuities, mutations and so forth. Kendall & Wickham describe 'archaeology in action' and list seven things archaeological research should do. It should: "chart the relation between the sayable and the visible; analyse the relation between one statement and other statements; formulate rules for the repeatability of statements (or...the use of statements); analyse the positions which are established between subjects (human beings) in regard to statements; describe 'surfaces of emergence' or places within which objects are designated and acted upon"(p.26) such as domains or settings; "describe 'institutions', which acquire authority and provide limits within which discursive objects may act or exist; and describe 'forms of specification'" (ibid).

Finally, Foucault's technique can be described as involving "what might be called a kind of lamination: building up citation upon citation, juxtaposing official and marginal discourses, quoting at length, rarely making heavily marked interpretive comments, allowing bits of cited text to carry the work, arranging and collecting historical fragments so that the order and arrangement of them, the technique of their montage perhaps, speaks for itself" (McHoul & Grace, 1993:21).

These various authors' strategies for approaching Foucauldian research, provide the basis for the (largely) archaeological analysis of the chosen archive (Chapters Three - Five). In those chapters I draw upon Sarup's 'back to the past' approach, using the idea of lamination to allow the discourses to speak for themselves, while describing and commenting upon changes and differences in discursive formation as they appear in the archive, and discussing the institutional, social and political conditions of the time. In Chapter Six, I re-work the curriculum documents, taking a more 'genealogical' approach to the final analysis. As the next section on genealogy suggests, such an analysis takes account of power and its relation to the discourse.

### **Genealogy of Power and Knowledge**

In this section, I focus on Foucault's analysis of power/knowledge and how this analysis contributes to the understanding of the emergence of the modern self through disciplinary technologies.

Genealogy grew from Foucault's desire to "develop methodological weapons to help him with his account of power"(Kendall & Wickham, 1999:29). As such, genealogy includes the archaeological work of examining statements in the archive, but adds in an analysis of power. By doing this, it can be seen as a way of putting archaeology to work, a way of linking it to our present concerns. It can be seen as the 'strategic development of archaeological research' (Bevis et al.1993; Dean 1994). As indicated above, Foucault was interested in how it is that certain discourses become dominant or more powerful than other discourses. His examination of this problem occurs within the context of knowledge and truth.

## ***Knowledge and Truth***

...truth is no doubt a form of power. And in saying that, I am only taking up one of the fundamental problems of Western philosophy when it poses these questions: Why, in fact, are we attached to the truth? Why the truth rather than lies? Why the truth rather than myth? Why the truth rather than illusion?...How is it that, in our societies, “the truth” has been given this value, this placing us absolutely under its thrall? (Foucault, 1988:107)

This provocative questioning is typical of Foucault’s critical stance, which I discuss in the next section under the heading Genealogy as ‘critical’. Foucault is clearly interested in truth, and how it is that we value it as we do. Given that we are attached to the truth, he is interested in the issue of how it is that particular truth claims come to be accepted as true knowledge (Dahlberg et.al., 1999). He is fascinated with the realisation that such claims might, in another time and place, not be accepted as truth.

Foucault (1980) discusses how he sees power operating to enforce the ‘truth’ of any set of statements. When power operates in this way, the ensuing discursive formation produces a ‘regime of truth’:

truth isn’t outside power...Truth is a thing of this world; it is produced only by virtue of multiple forms of constraint....And it induces regular effects of power. Each society has its regime of truth, its ‘general politics’ of truth; that is, the types of discourses which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish ‘true’ and ‘false’ statements; the means by which each is sanctioned; and the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (Foucault, 1980:131).

A regime of truth is based upon what is accepted as true knowledge. Foucault proposes that knowledge is much more a matter of the social, historical and political conditions under which statements come to count as true or false (McHoul & Grace, 1993; Loveridge, 1999). Foucault is not saying that ‘there is no truth’. Instead he is proposing

the idea that there can sometimes be many truths, each with its own rationality (McHoul & Grace). In developing genealogy as an analytical tool, he is attempting to find a method to answer the question “which of these [truths], at any given period, comes to predominate and how?”(p.19). This is the task of genealogy.

### ***Genealogy as ‘critical’***

In comparison with archaeology, genealogy is critical in the following sense. It is ‘niggardly’ (Kendall & Wickham, 1999), but it can also be seen as playful and child-like, “a methodological device with the same effect as a precocious child at a dinner party: [it] makes the older guests at the table of intellectual analysis feel decidedly uncomfortable by pointing out things about their origins and functions that they would rather remain hidden” (p.29). In the previous section, Foucault asked why we value truth, not lies. Such a question is unsettling, provocative, or critical.

A genealogical analysis occurs on two fronts. The first is the critical task of dealing with “forms of exclusion, limitation and appropriation...how they are formed, in answer to which needs, how they are modified and displaced, which constraints they have effectively exercised, to what extent they have been worked on” (Foucault, 1972, cited in Ritzer, 1997:46). Such a critique involves an analysis of the processes involved in the control of discourse (Ritzer). The second, or genealogical, task is to examine “how series of discourse are formed, through, in spite of, or with the aid of these systems of constraint: what were the specific norms for each, and what were the conditions of appearance, growth and variation” (Foucault, 1972, cited in Ritzer, 1997:46). In the context of this thesis, I will argue that various conditions constrained or enabled what could or could not be said in the writing of the Health and Physical Education in the NZ Curriculum (1999). I will examine some of the political and social conditions and power relations which prevailed during the time of the writing of the curriculum, and examine the educational and curriculum environment of the time in an attempt to analyse the ‘systems of constraint’ at work during this period.

Genealogy has a respect for, and interest in, knowledges that have been marginalised, forgotten or even derided. Foucault is supportive of a ‘resuscitation of subjugated

knowledges', that is, a proper airing of 'other' knowledges. One of his meanings of subjugated knowledge is to do with historical knowledge which is revealed by scholarly criticism. His other meaning is:

a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity...It is through the reappearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work (Foucault, 1980:82).

We will see how certain early public health health education discourses became marginalised and even derided in the latter part of the twentieth century. The reappearance of these discourses in more recent times has provided a climate of criticism for the analysis of 'taken-for-granted' knowledge in health education and health promotion.

As has been discussed earlier, Foucault's archaeology differs from traditional historical analysis. In much the same way, genealogical analysis also differs in several ways from traditional forms of historical analysis. It does not attempt to place events within grand explanatory systems and linear processes; nor does it highlight great moments or important people; neither does it attempt to pin down historical origins (Sarup, 1993). Instead, genealogical analysis:

attempts to establish and preserve the singularity of events, turns away from the spectacular in favour of the discredited, the neglected and a whole range of phenomena which have been denied a history. It rejects the pursuit of the origin in favour of a conception of historical beginnings as lowly, complex and contingent. It attempts to reveal the multiplicity of factors behind an event and the fragility of historical forms...there can be no constants, no essences, no immobile forms of uninterrupted continuities structuring the past (p.59).

Genealogy then, stands in opposition to such meta narratives<sup>10</sup>. Foucault's view of the Enlightenment<sup>11</sup>, for instance, is that it was merely "one particular historically dated and culture-specific discourse whose truth-claims and values amounted to no more than a transient episode in the modern history of ideas" (p.75). Behind this idea lurks a nest of questions: how do particular discourses become paramount?; how is it possible that certain knowledges become powerful?; and what is the relationship between knowledge and power?

### ***Discourse, knowledge and power***

Foucault established a deep and intimate relationship between discourse, knowledge and power. Dominant discursive regimes, or regimes of truth serve a regulatory function; in line with the social constructionist ideas<sup>12</sup> which underpin this thesis, they organize our experience of the world. They influence, or govern, our ideas, thoughts and actions in a specific direction. But they also constitute boundaries, through processes of inclusion and exclusion, for what during a specific time epoch and in a specific culture is seen as 'the truth', and 'the right thing to do'. Dominant discourses by their very nature "exclude alternative ways of understanding and interpreting the world" (Dahlberg et.al. 1999:31).

Foucault's writings lead us to an understanding of discourse as dangerous; dangerous to the extent that those in power take control of certain discourses either to bolster their own power, or to silence those discourses that they consider to be a threat to their authority (Ritzer, 1997). Any available discourse is able to be "appropriated in the interests of the relatively powerful" (Burr, 1995:69). As we shall see in Section Two certain discourses became appropriated and used in the Health and Physical Education in the NZ Curriculum (1999), and have been wielded in such a way as to marginalise other discourses. As Burr (1995) puts it, "discourses are embedded in power relations, and therefore have political effects" (p.62). The political and social effects of the Health and Physical Education in the NZ Curriculum (1999) are now making themselves

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<sup>10</sup> See Chapter Two.

<sup>11</sup> See Chapter Two.

<sup>12</sup> See Chapter Two

apparent as schools and school communities begin to grapple with the changes required to implement a health promotion (rather than a health education) document. As we shall see in Chapters Three and Four, teachers are being asked to change their pedagogical and classroom practices as a result of the curriculum approaches. In addition, the way they see themselves in relation to their community is dramatically changed in response to the curriculum.

Foucault's conception of power rests on the idea that it is diffused 'throughout the entire social formation' (Olssen, 1999). It is not possessed by, say, kings and politicians, but is 'exercised'. For instance schools, Ministries, and public health offices are essential to the 'operations of social power' (ibid.). Foucault saw power in a positive (not negative) way, producing our realities, our domains of knowledge and 'rituals of truth'.

Foucault believed that where there is power, there is also resistance and contestation. "Discourses...are always implicitly being contested by other discourses" (Burr, 1995:74-5). It is resistance to other competing, contradictory or similar discourses that defines power, and also allows for the possibility of social and personal change. Foucault believes that "knowledge-power is always contested; there is always ongoing resistance to it" (Ritzer, 1997:47) and that this ensures history shifts from "one system of domination (based on knowledge) to another" (p.47). Such a knowledge-based system of domination shapes our understanding of the world. It does this by offering descriptions and explanations that we understand to be true. Health educators have, to varying degrees, attempted to resist the power of the medical system and the descriptions and explanations it provides regarding health and well-being. Foucault, with his interest in the relationship between knowledge, truth and power, believes that such systems of domination also provide techniques of normalisation, such as 'surveillance, measurement, categorization, regulation and evaluation (Dahlberg et.al., 1999). Clearly the medical system uses such techniques of normalisation to great effect. Foucault's observation that systems of domination also provide techniques of normalisation opens up the idea of disciplinary power.

### ***Discipline and Governance***

Disciplinary power is power that shapes people in certain ways. Foucault uses the term disciplinary power in two different but related ways. Firstly, there is the power that comes from bodies of knowledge, such as the medical discipline. “In the operation of disciplinary power, knowledge of what makes up individuals and characterizes (sic) populations shapes them in essential ways; the social sciences have played a particularly important role in this respect by making objectivist knowledge the classificatory criteria through which individuals are disciplined and self-regulated” (Dahlberg et.al., 1999:30). The health system that operates in the western world shapes the way in which we act in relation to our health and well-being. We are urged to seek medical advice and accept medical intervention whenever we are not feeling well. We are classified as well or sick to varying degrees; our behaviours are judged healthy or unhealthy. Depending on our classification within socio-economic scales, we are provided with different levels of access and quality of health care. The second, related sense of the term has to do with this idea of self-regulation; power is expressed in the way it disciplines, shapes or coerces people by getting people to self discipline and regulate their behaviours and actions. Rather than relying on outside regulations (ie. police, health inspectors etc.) power is manifest in the way in which people take on the personal responsibility to be ‘good’ or ‘healthy’ social subjects.

Foucault’s move into disciplinary power is of particular interest to health education and health promotion. As I will argue in Section Two, much of the work of disciplines such as some social sciences and the medical discipline involves various attempts at shaping individuals and populations towards health, healthy behaviour or healthy lifestyles. The objectivist knowledge derived from medical science is readily used as a means of disciplining and regulating individuals and populations towards various health goals. For instance, research findings that show that tobacco is carcinogenic are used to urge people (through various means) to be smoke-free; evidence that certain foods are high in saturated fat is used to move people towards other sources of (less dangerous) fat in their diets. Objectivist knowledge derived from social science is used in a similar fashion. For instance, research findings that show high national rates of youth suicide

are used to persuade schools to develop policies for the identification of, and appropriate response to suicidal or depressed students.

Foucault is interested in the techniques and the technologies that are derived from knowledge, and how they are used by institutions to exert power over people (Ritzer, 1997) who in turn discipline themselves. One of Foucault's most colourful examples of techniques or technologies of power is his description of the panopticon in *Discipline and Punish* (Foucault, 1995). The panopticon is an architectural apparatus (a prison design) that gives prison officials full visual coverage of all prisoners at all times. Because of this design, the prison officials are able to gather information and exercise power over the inmates. A key feature is that the officials' power lies more in the design and architectural structure (or the technology) and in the larger prison system, than in the people involved. The technology is such that the prisoners come to control themselves; they stop themselves from doing various things because they fear that they might be seen by the officials who might be in the Panopticon. The link between knowledge, technology, and power as illustrated by the panopticon, can be used in other settings. Whenever a knowledge and technology are used to gather information about people, a power relation is born. Such power relations can be seen operating in the wider society, "the disciplinary society, a society based on surveillance" (Ritzer, 1997:61).

As we shall see later in this chapter, and in Section Two, technologies of discipline and surveillance have been developed and used by health educators and health promoters. As such, they may find themselves as tools of the disciplinary or self-regulating society. Often health educators and health promoters are unwitting tools or agents - they are unaware that they have taken up discourses that contribute to discipline and regulation by promoting, say, responsibility for personal health decision-making. Such decision-making may be useful in reducing morbidity and consequently reduce medical costs which would otherwise be borne by the taxpayer. Those who are aware that their discourse shapes people toward certain socially desirable ends, may be unaware that they have been constituted by the same discourses. A health educator who has steadfastly resisted a medical or individual behaviour-change discourse (perhaps

because she believes it contributes to a neo-liberal ideology), may find herself upholding the same political ends by utilising a decision-making or critical action discourse.

Discipline “may be identified neither with an institution nor with an apparatus; it is a type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a ‘physics’ or an ‘anatomy’ of power, a technology” (Foucault, 1995:215). As these systems of power become more fully developed, they can become costly, large and unwieldy. One way of ensuring that such systems become cheaper, more efficient, and more effective as a means of control is to utilise professionals as they carry out their regular professional tasks (Ritzer, 1997). So physicians, teachers, social workers, and health promoters might easily find themselves part of that ‘set of instruments’ which can be brought into play in an anatomy of power. For example, a health teacher could be seen as such an instrument through her efforts in encouraging students towards personal responsibility for health. In so doing, she could be seen as assisting in the control of people through encouraging self control and self regulation. The health teacher’s knowledge of how to invite people to take responsibility for their actions and decisions generates its own form of power by constituting people as responsible subjects. In this way, the health teacher’s knowledge is being used to govern subjects - in this case, students.

One writer who takes up this idea in the preventive health area is Petersen, who draws on the work of Castel (1991). Castel’s argument is that over the past century, there has been a shift in emphasis from controlling the dangerous or ‘at risk’ individual (for instance a person with a communicable disease such as leprosy or AIDS, or a smoker) to an emphasis on anticipating and preventing the emergence of undesirable events such as illness, abnormality or unhealthy or deviant behaviour. This is a different sort of coercion from the controlling coercion of the past. Foucault sees the law, religion and medicine as ‘institutions of normative coercion’ (Turner, 1992) with the ability “to exercise a power of normalization (sic)” (Foucault, 1995:308). Institutions such as the law, religion and medicine are coercive in the sense that they discipline individuals and exercise forms of surveillance over everyday life. They are not coercive in a violent or authoritarian sense because they are regarded as legitimate and normative at the

everyday level. “These institutions of normative coercion exercise a moral authority over the individual by explaining individual ‘problems’ and providing solutions for them” (Petersen & Bunton, 1997:xiv). In this sense it could be said that medicine, religion and health education /promotion “exercise a hegemonic authority because their coercive character is often disguised and masked by their normative involvement in the troubles and problems of individuals. They are coercive, normative and also voluntary” (p.xiv).

Castel (1991) draws attention to the emergence of preventive strategies of social administration which “dissolve the notion of the subject or a concrete individual, and put in its place a combinatory of factors, the factors of risk” (p.281). Castel’s idea can be applied equally to the preventive strategies of health promotion. Rather than using the face-to-face interventions of preventive medicine or the coercive use of confinement or isolation, health promotion strategies impose a far more subtle and effective mode of population regulation than the early methods of identification and control of aberrant individuals. Sarup (1993) argues in a similar vein, that these new techniques of power were needed to grapple with an increased population, to administer it and control it and to deal with the “newly-arising problems of public health, hygiene, housing conditions, longevity, fertility, sex” (p.68). Loveridge (1999), drawing on Foucault (1995), believes that the aim of such disciplinary technology is to create a docile body. This allows people to be “subjected, used, transformed and improved, by using new kinds of knowledge”(1999:8). She suggests that this new kind of knowledge comprises information “both of the population and of individuals and their experiences” (p.8). These new kinds of knowledge, or ‘official knowledges’ (i.e. the curriculum) work as instruments of normalisation, continually attempting to manoeuvre populations into ‘normal’, correct forms of thinking and behaving. McHoul & Grace (1993) note that “Foucault has an interest in examining the methods, practices and techniques by which official discourses go about this process of normalisation” (p.17).

Foucault’s insights into power, knowledge, discipline and self-regulation are tools to draw upon in the later analysis of the archive (Section Two). They move the analysis away from an emphasis on the form and grammar of language, to a consideration of the

function and use of language within a discursive field, in this case, the field of health education/promotion. As such they are key tools in helping me approach such questions as 'how does a certain discourse come to predominate?' and 'is the curriculum discourse able to be used as a tool by <sup>only</sup> nay particular political ideology to gain or maintain power and dominance?' These questions just can not be adequately addressed by archaeology alone.

## Techniques of the Self

As I have already indicated, Foucault's thinking shifted during the course of his writing, these shifts occurring gradually, in an 'overlapping' manner. Various writers (Harrison, 1987; Bevis et al 1993; Rabinow, 1997) have noted the shift in Foucault's thinking that occurred between the publication of the first volume of *The history of Sexuality* (Foucault, 1976/1990) and the publication of the later two volumes, *The Use of Pleasure* (Foucault, 1984/1992) and *The Care of the Self* (Foucault, 1984/1986). One way of looking at this shift in Foucault's thinking is to consider it as a move from a genealogy of power to a genealogy of self-awareness, self-control and self-practices (Ritzer, 1997). My interest as a health promoter in this shift, is in the genealogy of self-control.

Already in the section above, I note the use of words such as 'abnormal', 'deviant' and 'aberrant'. Disciplinary power achieves its goals through the imposition of conformity. It is essentially normalising. Armstrong (1983) refers to this technique for managing populations as the 'apparatus of normalisation'. An apparatus is a "structure of heterogeneous elements such as discourses, laws, institutions, in short, the said as much as the unsaid. The apparatus contains strategies of relations of forces supporting, and supported by, types of knowledge" (Sarup, 1993:65). Health educators and health promoters use various apparatus of normalisation, for example, by drawing upon epidemiological data. Such data allows them to determine what is normal or abnormal, healthy or unhealthy, safe or risky. They then develop measures and other practices common in the social sciences, to assess if individuals are normal. Their task from that point is to shape individuals and communities towards that norm.

### ***Biopower and Governmentality***

In the first volume of his *The History of Sexuality* (1976/1990), Foucault developed the concept of bio-power. Bio-power, or 'power over life' (Hakosalo, 1991) refers to the mechanisms employed to manage the population and discipline individuals - to manage people's lives. Because such things as population, reproduction and disease are central to economic processes, they need to be subject to political control. Therefore, Foucault argued, biological life is a political event, with governments using bio-power to maintain control over the population. A problem that gets in the way of this is that of human rights. In order to maintain control over people in this climate, governments have had to develop increasingly refined strategies as human rights ideals have become increasingly established. Health promotion strategies (along with many other similar social administration strategies) enhance the set of power techniques a government can use to control and manage the population while avoiding coercive actions that might contravene human rights principles (Gastaldo, 1997).

Gastaldo (1997) argues that health education has come to play an increasingly important role in the exercise of bio-power. Her argument is that through its association with illness prevention and health promotion, health education contributes to the management of social and individual bodies by introducing new knowledge, surveillance and disciplinary techniques into everyday life. By encouraging subjects to make decisions about their health and become actively involved in the care of themselves and their communities, health education appeals to such notions as self-autonomy and self-governance. Writers such as Gastaldo emphasise the "complexity of modern relations of power which depend not upon the direct control of subjects through coercive means but rather upon creating a sphere for their regulated autonomy" (pp.5-6). Dahlberg, et.al., (1999) suggest that rather than using coercive or physically controlling techniques, the exercise of a technique such as bio-power steers or guides the subject to 'desired end preferably without their awareness of what is happening'. This technique is common among many modern health educators and health promoters who take a facilitatory and empowering approach in preference to a didactic approach or the use of blatant 'scare' tactics. This use of subtle persuasion by health educators and health promoters as a technique of disciplinary power is designed to move people to behave in

a certain way “without provoking them into thinking critically about what they are being asked to do” (Ransom, 1997:30-1, emphasis added).

A new kind of power arose with novel tactics and new strategic objectives. At the heart of this change was a displacement in the theory and practice of statecraft away from the sovereignty of the monarch and towards a concern for ‘government’, where the latter refers not only to the person governing but also to a wide variety of efforts in both the ‘public’ and ‘private’ spheres to shape the human material at one’s disposal...Governance, as it turned out, had less to do with forcing people to do what the sovereign wanted and more to do with steering them in the desired direction without coercion (ibid.:28-29, emphasis added).

In *Madness and Civilisation* (1961/1988) Foucault talks about how human beings have been released from physical chains, but these have been replaced by mental ones; external violence has been replaced by internalisation. Rather than viewing power as residing in a king (monarchical power), or the law (judicial power) where it limits, obstructs, refuses, prohibits and censors, Foucault preferred to view power as disciplinary power, a “system of surveillance which is interiorized to the point that each person is his or her own overseer. Power is thus exercised continuously at a minimal cost” (Sarup, 1993:67). In contrast, monarchical and judicial power can be seen as the power to say no. It is a possession or a capacity. It can be seen as the property of an individual or class, a commodity. The challenging of such power is regarded as a transgression. On the other hand, modern disciplinary power operates quite differently. Rather than being negative (the power to say no), Foucault believes that it operates through the construction of new capacities and modes of activity’. Foucault’s writings emphasise the positive and productive as well as the repressive nature of power.

What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole

social body, much more than as a negative instance whose function is repression (Foucault, 1980:119).

Disciplinary power can be thought of as strategic. "There is a shift from 'Who has power?' or 'What intentions or aims do power holders have?' to the processes by which subjects are constituted as effects of power" (Sarup, 1993:74). It is my argument that there has been a move from a health education discourse to a health promotion discourse in the curriculum, with a parallel move from coercive techniques to strategic, disciplinary, internalised techniques of power.

### ***Subject positions, autonomy and ethics***

Finally Foucault's life and writing comes to an end. Given all that has gone before, he leaves a sense in which individuals, through subtle techniques of disciplinary and bio-power, are being coerced, manoeuvred and controlled. We may ask, so who is doing this coercing, manoeuvring and controlling? Of course, this is not a question that Foucault would ask. His critical method locates power outside the conscious or intentional decision of a person or people. He does not ask, who is in power? He asks how power:

installs itself and produces real material effects; where one such effect might be a particular kind of subject who will in turn act as a channel for the flow of power itself. Foucault does not turn to the 'authors' of power but to the field of power (McHoul & Grace, 1993:21).

Foucault's analysis of power has brought us to the point where we see power very differently from the ways we have before. Power can no longer be seen in terms of one individual's domination over another person or people.

Let us not...ask why certain people want to dominate, what they seek, what is their overall strategy. Let us ask, instead, how things work at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviours etc. In other words, rather than ask ourselves how [for example] the sovereign appears to us in his lofty isolation, we should

try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts, etc. We should try to grasp subjection in its material instance as a constitution of subjects (Foucault, 1980:97).

Neither can it be seen as one class's domination over another class. Instead, as we have seen, power is comprised of "instruments for the formation and recording of knowledge (registers and archives), methods of observation, techniques of registration, procedures for investigation, apparatuses of control and so forth" (McHoul & Grace, 1993:22). This view of power has the effect of creating or constituting subjects. So we have 'the prisoner', 'the criminal', the 'person with AIDS', the 'high health risk individual', the 'learner', the 'teacher'. Once constituted in such ways, individuals become part of the mechanisms of power, they are part of the field of power. Foucault's method allows us to "examine subjection, the processes of the construction of subjects in and as a collection of techniques or flows of power which run through the whole of a particular social body" (McHoul & Grace, 1993:22). The human subject is now seen as being simultaneously produced by discourse and as manipulating it. We each hold various subject positions - we occupy various slots such as young, obese, feminine or lazy, and these subject positions limit what we may or may not do (Burr, 1995). As we have seen, these subject positions also hold us in webs of disciplinary power relations. So, "power is both reflexive...and impersonal. It acts in a relatively autonomous way and produces subjects just as much as, or even more than, subjects reproduce it" (McHoul & Grace, p.22).

So how 'free' are individuals within such a web of power relations? Are people able to make their own decisions? Are they autonomous individuals? If discourses address us as particular kinds of people (as an old person, a mother, a dole-bludger, a bright student or a homosexual), and we cannot avoid these subject positions, then what are our choices? We can accept (or fail to resist) a position and the way that position represents us to others. If we do, we are clearly locked into the system which has positioned ourselves in that way, locked in to the system of rights and obligations that are carried with that position (Davies & Harre, 1990; Burr, 1995). Conversely, we can attempt to

resist our assigned subject positions. Resistance however, has no object (like a king) to resist against. It must use the discourses of the system itself to resist, thus binding the 'resister' further into the web of power relations. Sarup (1993) suggests that Foucault's methods go some way towards understanding how such resistance can occur, by attempting to "rediscover the interaction of discourses as weapons of attack and defence in the relations of power and knowledge"(p.66). Ransom (cited in Dahlberg, et.al., 1997) suggests that people can learn how not to be governed so much. He believes that disciplinary power can be resisted and that we "can potentially thwart, challenge or at least question the ways in which we have been made" (p.33).

Foucault sees individuals as moral agents to the extent to which they work out the methods and techniques at play in relation to a subject position, and the extent to which they use a range of practices which 'enable them to transform their own mode of being' (Foucault, 1984/1992). This is in contrast to a person using a code of moral or ethical behaviour to dictate her/his behaviour. Foucauldian ethics relies on 'the relation one has to oneself' (McHoul & Grace, 1993). The way in which Foucault's methodology focuses not on theoretical texts but rather on prescriptive, practical texts of the historical periods he is analysing, thus enabling "individuals to question their own conduct, to watch over and give shape to it, and to shape themselves as ethical subjects" (Foucault, 1984/1992:13, italics added)

The genealogical analyst will, according to the Foucauldian view, be "immersed within and subject to discourse" (Loveridge, 1999:19). The ethical Foucauldian analyst must become reflexively aware of her/his unique position within the discourse, and examine the subject positions (s)he holds. Drawing on the work of Bauman's (1993) postmodern ethics, Dahlberg et. al. (1999) argue that we must "repersonalize (sic) morality, become our own moral agents, recognizing (sic) that we bear responsibility for making moral choices for which there are no foolproof guidelines offering unambiguously good solutions" (p.38). In Chapter Two I discuss how I see myself as a reflexive researcher. Certainly, my years working in the field of health education and health promotion means that I am already immersed in these discourses. This raises a problem with the way in which I have chosen to undertake the archaeological analysis.

The method (Sarup, 1993) relies on uncovering older and older discourses which gives a sense of surprise with each 'uncovering'. The problem, which I discuss in Chapter Six, rests on the situation of my personally knowing discourses (through long-term immersion in the discursive field) prior to them being uncovered and described through analysis.

On the question of ethics, I do acknowledge my own unique position within the discourses under analysis, particularly those discourses that have appeared following consultation and feed back (i.e. draft versions of the curriculum), and the part I have played preparing a generation of teachers for the classroom, by my use of my own versions of health education and health promotion discourses. My own position is clear - health education's role is to use education strategies to improve health outcomes. In health education, these strategies include the provision of health knowledge<sup>13</sup> and the opportunity for critique of that knowledge; the exploration and challenging of learners' attitudes, values and beliefs; and the teaching and practice of health skills (i.e. decision-making, communication, critical analysis, self-care etc.). I do not agree with the view that health education, and especially school health education (Ministry of Education, 1999), should include a health promotion role as well. I raise this at this point, because of the ethics behind the stance. Firstly, because of the possibility of harm to others, professionals should never undertake work which exceeds their expertise or competence, or which is not supported by adequate resources. Teachers are being asked to take a health promotion approach as they implement the curriculum, without adequate knowledge of health promotion, the adverse effects it can have on individuals and on communities in the hands of the inadequately-prepared practitioner, or without classroom or structural supports in place to strengthen their health promotion endeavours. Secondly the time teachers are taking from their health education programmes to deal with health promotion reduces the effectiveness of their health education programmes, reducing learners' health-learning opportunities. Finally, it has

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<sup>13</sup> My view of health knowledge in the context of effective health education is that it is as broad, diverse and complex as the educator can conceive. It can include knowledge of the human body, the human condition, institutions and systems, society, environment, and the determinants of health and well-being.

been my observation that whenever a person is asked to take on new roles or to change their approach, they are placed under increased stress and demands. With no evidence to suggest that the change in role and approach will positively affect the health outcomes for learners, this increased workload demand on teachers is, I believe, unacceptable.

Foucault's view of ethics does not rest easy with me. I prefer the view that collectivities (say, teachers, or public health workers) should decide the ethical stance and principles that should then be enacted by each member of the collectivity, for its good and the good of its 'stakeholders'). I find it difficult to give primacy to the individual and her own self-regulating morality with its links to individualistic neo-liberalism (see Chapter Two).

## **Conclusion**

Having reviewed Foucault's views and positions on language, power and the self, some key questions and issues emerge in relation to this thesis. It is clear that not all of the tools developed by Foucault will be able to be used adequately in the analysis of my chosen discursive field. However, because of my interest in language my emphasis will be on archaeology rather than genealogy, in an attempt to find the rules that allow certain discourses to emerge and 'descend', and to find the rules that define how discourses are used, at different times, and in different contexts. While I acknowledge the way in which genealogy adds a critical perspective to such an analysis, I will be placing the greater analytical energy into this archaeological analysis (Chapters Three, Four and Five). A genealogical analysis is rather woven in to the Chapters Three, Four and Five, and given more focus in Chapter Six.

Having reached this point with the work of Foucault, one 'reading' of his work, gives a distinct impression of pessimism and bleakness:

...For the intellectuals of cultural despair, from Eliot and Ezra Pound to Marcuse and Foucault, all of modern life seems uniformly hollow, sterile, flat,

'one-dimensional', empty of human possibilities. Anything that looks or feels like freedom or beauty is really only a screen for more profound enslavement and horror. There is no freedom in Foucault's world, nor does he have a theory of emancipation. The more powerful the vision of some increasingly total system or logic, the more powerless the reader comes to feel. The critical capacity of Foucault's work is paralysed because the reader is made to think that the project of social transformation is vain, trivial, hopeless (Habermas, 1982:28).

Many health educators, quite separate from any reading of Foucault, arrive at this point in the course of their work. My observation over the years, is that health educators often realise a certain futility to their enterprise, and that their attempts at empowering learners to make choices conducive to health often fail. While Habermas saw Foucault's position in this pessimistic way, others (e.g. Weeks, 1985; McNay, 1994; Falzon, 1998) see Foucault's position instead offering positive ethical challenges. Olssen (1999) suggests that Foucault was, ultimately, an optimist about "the possibilities of emancipation and the ability of people to direct the course of human events" (p.30). He is of the view that Foucault's conception of power, along with his emphasis on the "contingent nature of life" (ibid.) provides hope that humans can transform their lives and their social and cultural structures.

This thesis attempts to take the positive aspects of Foucault's work as it charts the discourses of health education and health promotion over the second half of the twentieth century.

## Chapter Two

### **Epistemological positions: social constructionism vs positivism**

In Chapter One, I discussed, among other things, Foucault's ideas about knowledge and truth. Foucault was writing from an epistemological position known as social constructionism. As I stated in the Overview, epistemology is about knowledge, or more specifically the philosophy of the nature of knowledge and truth. Foucault's social constructionist epistemology is complex and rather difficult to understand. But viewed against other (more familiar) epistemologies, it can, I believe, be better understood. The following chapter attempts to explain the social constructionist position, and does so by comparing it to other epistemologies, especially the epistemological position of positivism. In doing so, I acknowledge the forceful critiques of social constructionism and of postmodernism (Callinicos, 1989; O'Neill, 1994) that challenge its epistemological arguments. However, the purpose of this chapter is not to engage with these critiques, but rather to elucidate, describe and clarify the position that Foucault has taken and to come to an understanding of how research might be carried out based upon such an epistemology. I do this initially by reviewing, with a broad brush, certain widely held epistemological (and research) positions that can be seen as opposed to social constructivism.

Secondly, the process of discussing various positions and discourses associated with positivism in this chapter leads to a discussion of liberalism and neo-liberalism. This is important in the context of this thesis because of neo-liberalism's prominent place in New Zealand's political and social landscape during much of the time relating to the archive under analysis.

## **Positivism and the Enlightenment Project**

The following elucidation and discussion of the positivist position is placed within the context of a long-term intellectual project often referred to as the Enlightenment project. Positivism is, I argue, the dominant intellectual position against which Foucault and other post-modernists were writing. The effects of positivist discourse have shaped our institutions, history, political structures and the material world lives of millions, shaping their lives as a result. The position is discursively linked to several different philosophies, theories, and ideas, which I briefly review in the following sub-sections.

### ***Realism and the referential theory of knowledge***

To help explain the Enlightenment project, a useful starting point is a particular epistemological position - epistemological realism. This position has enjoyed such wide acceptance within western thought for several centuries that it seems commonsensical to most western-thinking people. It asserts that the objects of our knowledge exist independently of human minds (they exist without the need for human minds to observe or know them). Proponents of this view believe that there is a real world out there, and that it is possible to have knowledge of that world. They believe not only that the world exists independently of us, but that it has also existed before our subsequent knowledge of it. This discourse opens up the idea that the world is somehow immutable and is there waiting to become known by human beings. We have seen in Chapter One that Foucault is instead open to the possibility of 'many truths', and that knowledge is better thought of as 'knowledges', some of which come to be accepted as true at certain times and in certain places, under certain social, historical and political conditions. There is a sense in which knowledge changes as human beings' situations change. For epistemological realists, the question is how do we gain access to the real world so that we can begin to know it? If the world exists independently of us, how do we connect with it? How can we gain knowledge of something separate from, and external to us? For Foucault, these questions are senseless.

Epistemological realism (first enunciated by Plato and Aristotle, later Aquinas, and more recently Pierce, Moore and Whitehead), asserts that we gain direct knowledge of

the world through the processes of physical sensory perception. Once an object in the real world is observed, it can then be referred to by using language. This 'referential' theory of knowledge maintains that when we observe something in the real world, say a shiny red roundish fruit, we are able to refer to it by labelling it 'apple' (or 'aporo' if we are speakers of Māori rather than English). Every thing, according to this view, can be referred to with appropriate language - our knowledge of every thing we perceive through our senses, such as the apple, but also every thing we come to understand through experience. Because we experience emotions and feelings, we are able to refer to our 'anger' or 'pain'. The referential theory goes beyond strict realism by admitting conceptual abstractions such as 'health' or 'illness' as aspects of knowledge derived from experience. Such abstractions are able to be referred to and labelled as if they are constructs that exist in the real world. Our perception and experience give rise to our knowledge. In addition, a priori knowledge, or knowledge generated by reason and deduction (i.e. mathematical equations or philosophical ideas) can be referred to as if they, too, exist in the real world. This focus on reference and labelling is important when attempting to understand epistemological realism. According to the referential theory, the world exists, we acquire knowledge of that world in a variety of ways, and subsequently we use language to label each aspect of that world.

The world therefore is waiting to be discovered by humans. This process of discovery has become a Western project of grand proportions. The 'Enlightenment Project' which aimed to fully discover, map, categorise and explain the 'knowable' world, came from this position of epistemological realism. The project has spanned many centuries but was 'revived' in the early seventeenth century with the European enlightenment by philosophers such as Descartes. The mission of the enlightenment project was to shed the light of reason and knowledge on all people. It has included such ancient endeavours as Aristotle's categorisation of the natural world, or James Cook's later mapping and naming of new lands, and more recently American scientists' discovery of the human genome. Those involved in the enlightenment project continue adding to our knowledge of the world with the expectation that one day we will have uncovered all knowledge and truth, and as a consequence will have the ability to reliably explain, predict and possibly even control all the phenomena in our world.

There are several philosophical problems with epistemological realism, not the least of which are to do with the processes and vagaries of observation and physical sensory perception. However, these and other misgivings regarding realism have not stopped the Western fascination with, and belief in the possibility of the enlightenment project. The project has promised to uncover and verify all knowledge and truth. Over the centuries several different methodologies (ie. theology, astrology, alchemy etc) have been attempted, with varying success, to achieve the aims of the project. With the rise of science however, empiricism and the empirical method came to be seen as a systematic and verifiable way of gaining knowledge and finding truth, The Truth. It is against such enlightenment views that Foucault can be seen to be writing from within a radically different epistemology.

### ***Empiricism, positivism, structuralism, and modernism***

Enlightenment views are to be found under many different names and guises, and closely linked to the related ideas and discourses of empiricism, positivism, structuralism, and modernism.

An empiricist discourse asserts that the sole source of knowledge is experience (a posteriori), or conversely, that no knowledge is possible without it first being experienced through the senses. Whereas earlier enlightenment scholars such as Descartes (and later Kant) placed importance on reason and allowed a priori knowledge, the empiricist denies the possibility of knowledge derived purely from reason or logic. There are philosophical difficulties with the idea that the rational mind is able to generate knowledge on its own (a priori knowledge), without any sensory perception required have been avoided by the empiricist. Strict empiricism only admits knowledge gained through sensory perception and experience. As discussed above, the discourse of the broader referential theory of knowledge includes such referents (gained by observation and experience), but also includes knowledge gained by reason and deduction because the objects of such knowledge are able to be referred to and labelled with language.

There is a wider discourse associated with the ideas discussed above, (ie. realism, the referential theory of knowledge and empiricism). Carnap of the Vienna Circle is credited with using the term positivism (also known as logical positivism) for the doctrine (closely associated with empiricism) that asserts that the highest form of knowledge is simple description of sensory phenomena. Rather than using the terms interchangeably in this thesis, I will use Carnap's term positivism whenever I am talking about scientific empiricism. Positivism can be thought of as a related discourse, an intellectual tradition, a paradigm, or a way of seeing the world. Proponents of this paradigm see the world in a certain way - independent of us, observable, accessible and knowable. Their discourse also includes a range of related ideas. One such idea is the importance of verification. If an observation is verified by several different scientists, it is more deserving of being labelled as knowledge than an observation made and reported by only one scientist. Foucault saw such a paradigm as a dominant discourse, dominant at a certain time in history, and for a certain group of people. I believe that one of his main aims was to resist this positivist discourse or paradigm, and suggest other ways of 'seeing the world'.

Another discourse related to the scientific and positivist traditions, is that of structuralism. Its discourse attempts to make sense of data and facts gained through experience or scientific endeavour by seeking to understand the underlying structures that exist beneath observed surfaces. Many scientists, including social scientists such as Marx and Weber, Chomsky and Levi-Strauss have attempted to do this. For instance Marx was interested in the underlying structures of society and Chomsky (1966) was interested in the underlying structure of language. As structuralists, both generally looked for frameworks, models and deeper explanations and sought to find the essence of things. A structuralist discourse is based on a belief in the order of the universe, of being able to ascertain patterns and trends. Clearly, Foucault would not be comfortable with this view, choosing instead to use a discourse of a constantly changing universe as people and their conditions change. His view is that we do each attempt to make sense of our world, but not in the way a structuralist discourse suggests, that is, the seeming chaos and jumble that confronts us in the world is yet to be understood as structured and patterned. Combined with a positivist approach, many structuralists believe that science

will one day make sense of our world, that the symmetry and order which they believe exists will be found. Eventually essential universal truths will emerge, a universal reality will be found and understood by all no matter where or when they live or what language they speak or culture they live in. When this occurs, the enlightenment project will have been completed.

It is clear that Foucault opposes this view. For him there are no universal truths, and no one universal reality. Instead there are many truths and realities, some of which come to dominate at different times in different places. Not until we understand how pervasive positivist discourses are, can we begin to think as Foucault does or realise just how profoundly different his project is.

By the turn of the twentieth century, the belief in the ability of science to find truth and structure was becoming expressed in the intellectual movement and discourses of modernism (or modernity). Modernism arose and developed during the nineteenth century, exerting an enormous influence throughout most of the twentieth century. On one front it found expression in the arts and in architecture. This modern aesthetic movement was anti-positivistic. It explored disintegration (rather than the positivist integration) and anti-representational ideas through such art forms as expressionism, impressionism, fauvism and surrealism, ideas I feel sure Foucault would have enjoyed. However, as an intellectual movement modernism can be seen as a continuation of the enlightenment project. Intellectual (rather than aesthetic) modernism makes an effort to understand the world rationally, and the process of achieving such an understanding helps to serve to 'disenchant the world' (Bauman, 1993). By disenchanting the world, modernists seek to explain and demystify phenomena. Modernist discourse casts aside superstition and prejudice in favour of reason, science and technology. Marginalised or non-dominant discourses remain marginalised and silent, a position in sharp opposition to that of Foucault.

As the twentieth century's enunciation of the enlightenment project, modernism was hailed as the means of contributing to progress, and towards hope for a brighter future. The accumulated experience of Western civilization, industrialization, urbanization,

advanced technology, the nation state and life in the fast lane were heralded as the way forward (Rosenau, 1992). As such, modernism is associated with technologies such as nuclear reactors where the focus is on maximally efficient and useful performance. Such technologies were expected to provide the ultimate solution of all society's problems. Modernist discourse, in Rosenau's view, prioritise such things as career, office, individual responsibility, bureaucracy, liberal democracy, tolerance, humanism, egalitarianism, detached experiment, evaluative criteria, neutral procedures, impersonal rules, and rationality. Clearly modernism is in part a continuation of the enlightenment project, but includes much more. The detached experiment and neutral procedures are certainly positivist priorities, but not the liberal democracy, tolerance, humanism or egalitarianism. There is a wider eclecticism and breadth to modernist discourse that is lacking with positivism. However beneath this eclecticism lies the enlightenment urge to get 'all the world's diverse peoples to see things the same way - the rational way' (Harvey, 1989). Such structures as bureaucracy, democracy and impersonal rules all work to ensure people do see things the same way. When people do see (and say) things the same way, often without question, it can be said they are operating within a discursive paradigm. Realism, positivism, structuralism and modernism are all parts of the same paradigm which essentially seeks to provide a rational explanation of our world. For Foucault, it was possible to resist and challenge this paradigm.

Liotard (1979/1984) believed that paradigms can be seen as 'grand narratives' or meta-narratives. He held an incredulity towards meta-narratives, especially the enlightenment idea that science legitimates itself as the bearer of emancipation (Lyon, 1994). Each part of the paradigm tells its own story in a particular way: positivism is speculative, cognitive-theoretical and scientific; modernism is emancipatory, practical and humanistic.

While each part of the paradigm is involved in furthering the enlightenment project, modernism has, as I have suggested, also become associated with other discourses, those of liberalism, individualism, humanism and capitalism. The following brief overview of these positions helps define the discursive rules that govern the meaningful use of the terms when used later in the thesis. As well, an understanding of liberalism,

individualism, humanism and capitalism adds to an understanding of epistemological realism, which is so important in the development of a firm understanding of Foucault's position and methodology.

***Liberalism: individualism, humanism, capitalism and neo-liberalism***

Orthodox modern discourses are underpinned by a meta-narrative of progress (Giddens, 1991; Beck, 1992). In addition, modernism is characterised by an evolving self-consciousness. Petersen (1997) suggest that when modernisation reaches a certain level, agents become 'individualised', that is less constrained by structures, and the self becomes a project to be 'reflexively fashioned'. Individuals must learn, on pain of permanent disadvantage, to conceive of themselves as the masters of their own fate, and to see events and conditions that happen to them to be a consequence of their own decisions. Modernists like Giddens and Beck see the individual as actively engaged in shaping his or her own biography by, for instance, choosing one's identity and group membership. We have already seen in Chapter One how this modern idea of the self-reflexive, autonomous subject is profoundly challenged by the work of Foucault and other post-modernists.

The discourse of individualism then, lies at the heart of liberalism which gives primacy to the individual, his or her concerns being more important than, and preceding those of society or any collectivity. In turn liberalism is supported by the belief that every person (more often man) has the ability to reason, and therefore the ability to determine truth and plan a course of action in accordance with personal interests. Clearly Foucault is critical of this stance. In his writings on disciplinary power, he questions a person's ability to determine their own actions. However, it is out of the tradition of liberalism that capitalism is given economic voice and primacy. What better economic doctrine for the liberal ideas outlined above? Within capitalism individuals are (believed to be) free to determine their own economic progress according to their own interests. In Chapter Three I explore the discourses of neo-liberalism that have been a tension within curriculum development on New Zealand over the past two decades. It is within the discourse of liberalism and capitalism that neo-liberalism and 'new right' philosophies reside.

However, many liberals also espouse humanist values such as equality, social justice, and empowerment, ideas that rely on human empathy and concern for others' progress. This seeming contradiction to the ideals of individual freedom and progress appears to be widely accepted by modern Western capitalist economies. It seems that liberal assumptions contribute to the contradictions and commonplaces that constitute the commonsense of the West (Arblaster, 1984). This 'commonplace commonsense' is one way of illustrating how paradigms become so 'taken-for-granted' that they become forms of legitimation, allowing certain narratives to become legitimate or dominant (Lyotard (1979/1984) - even in face of clear contradiction.

If any paradigm or discourse goes unchallenged or unquestioned, it risks the likelihood of becoming dogma, or closed-off to other possibilities. At that point there can be no other conceivable way of seeing the world. Not only that, there is (if paradigm becomes dogma) no other methodology - other than the methodology(ies) favoured by the paradigm - that are able to provide us with knowledge of the world or understanding of human experience. The question of whether the positivist and modern paradigms have become dogma or dominant discourses, or whether it is possible to question the paradigms and their epistemological underpinnings is beginning to be asked more frequently, and with more urgency. This has happened as certain social changes and events such as the horror of the holocaust following the implementation of National Socialist (positivist) doctrines, the dubious ethics of many empirical scientific experiments, and 'advances' such as genetic engineering have begun to chip away at the certainty of modernity. The question begs others: are there other ways of seeing the world, other discourses, other possible paradigms? And, in the context of this thesis, where do health education and health promotion discourses sit?

### ***Positivism and the Enlightenment Project challenged***

This thesis is being written at a time in history when realist, positivist discourses are facing critical challenge, especially from many social scientists. Over the course of the twentieth century the aims of positivism and modernism, as well as the epistemological bases of the paradigms, have come under the critical gaze and the increasing scrutiny of scholars such as Eco, Jencks, Baudrillard and Foucault. Of interest to me is the

epistemological challenge from the discourses of post-structuralism and post-modernism, and especially the epistemology of social constructionism. This critical challenge begins by questioning the very bases upon which structuralism was built, its theory of knowledge (its epistemological assumptions), its ontology and its aims.

Instead of accepting as true all that positivist science believes is true, many post-structuralists and post-modernists such as Foucault ask 'are there other ways of talking about the world, human beings and their experiences?' and 'are there other ways (other than perception and experience) by which we can gain knowledge?' other than by using the meta-narratives of positivism and modernism. This thesis is firmly embedded within the debate that arises from these questions. It will attempt to question, as Foucault did, the 'taken-for-granted' views, ideas and understandings of the world which arise from positivist-structuralist and modern assumptions.

The ideas of science, empiricism, positivism, modernism and liberalism have created a powerful legacy, a mind-set which is seductive and captivating. Liberal ideals are taken-for-granted within western capitalist societies. It seems common-sense that the world exists independently of us, that we gain our knowledge of that world through sensory perception, experience and reason, and that we use language to refer to objects and constructs in that world. However, as Foucault and others have shown, there are other ways of seeing how knowledge is generated. Foucault's way of seeing the world rests upon a social constructionist epistemology.

### **Social constructionism and a non-referential theory of knowledge**

Epistemologically, social constructionism differs from the referential theory in several key ways. The point of greatest difference is that knowledge is not something out there waiting to be discovered and labelled, but rather knowledge is constructed between people through their daily interactions with each other. Social constructionists believe that when people interact, they are involved in creating and constructing versions of reality, "When people talk to each other, the world gets constructed," (Burr, 1995:7).

Social constructionism suggests that there is not one reality out there, but multiple versions of reality which are constructed by people when ever they use language.

Burr (1995) explains this epistemological stance, and how language is the key to understanding this idea. As outlined earlier, the referential view of a pre-existing world which we perceive and which we can talk about, maintains that language is a way of describing reality. According to that view language signifies and labels objects and ideas. However, the social constructionist sees language quite differently. Rather than reality and thoughts preceding language and subsequently being described by language, the social constructionist sees language preceding and shaping our reality and our thoughts:

the way people think, the very categories and concepts that provide a framework of meaning for them are provided by the language that they use. Language therefore is a necessary pre-condition for thought as we know it (pp.6-7).

Burr explores this idea in depth, questioning our taken-for-granted ideas, and explaining that our feelings and emotions, our attitudes and thoughts are constructed through the language we use. Our attitudes and thoughts do not pre-date our language, but rather, are made possible by language (Sapir, 1949). In line with the Sapir-Whorf hypothesis regarding linguistic relativity and grammatical categories (Lucy, 1992) Burr argues that if there is no way to express a particular concept in a language, then that concept just cannot be used by the people who speak that language. For Foucault, his approach to discourse highlights the way in which our language is rule-bound and constrained. A field of discourse allows people to talk about a topic. However, unless the discursive rules and practices are in place and agreed upon, people will find it impossible to communicate with each other in that field of discourse. I have already discussed how discourses change and mutate over time. The rules and practices change, elements from other discourses are drawn upon and brought within another, traces of older discourses remain in new, discourses are captured, and the processes of interpretation and social practices mean discourses are rarely set in concrete.

So, instead of language being a system of signs with fixed meanings upon which everyone agrees, it is rather a “site of variability, disagreement and potential conflict,” (Burr, 1995:41). This is particularly pertinent when talking about such abstractions as ideas and concepts. Parker (1992) explains how languages, or discourses allow us to see things that are not ‘really’ there, and that once an idea has been elaborated in a discourse it is difficult not to refer to it as if it were real - an ‘ontological illusion’ (Harré, 1986). Parker suggests that a concept such as, say, ‘health promotion’, can be ‘called into being’ through discourse, and thus given a reality which can have real effects upon people. As I have explained previously, the commonly-held referentialist view is that concepts such as health, or feelings such as anger and love, exist independently of language. A social constructionist resists this conclusion. Instead, concepts such as health and illness become objects of epistemological knowledge when they are created through discourse. The danger is to take the realist stance and to think of such concepts as having ontological status, or existing independently of human thought processes or of language. Instead, many social constructionists assert that nothing exists beyond the text (Derrida, 1976); we cannot have direct knowledge of ontological objects because there are perceptual, linguistic and constructive processes mediating between the object and the knowing. We can however call the object into being by talking about it and giving it epistemological status. The positivist’s problem of a priori knowledge is not a problem for social constructionists. Through discourse, we can talk about ideas and concepts whose status has no basis in perception at all (ie many philosophical ideas, religious concepts etc).

There are several other key elements of a Foucauldian social constructionist stance that challenge a realist epistemology. In Chapter One, it was shown how a social constructionist stance such as Foucault’s is critical and wary of taken-for-granted knowledge and of the accepted versions of truth and reality; it recognises that knowledge and truth are relative, that is they are historically and culturally specific, that there cannot be any given, determined nature to the world; and rather than attempting to find the essence of things, external reality, or the knowledge that people have, the social constructionist focuses on people’s interactive processes, especially people’s discourse (Burr, 1995). Because social constructionists such as Foucault hold this view that

language does not just describe reality, but that it rather constructs our versions of reality, their research readily focuses on language and discourse. In this way, this thesis will focus on language and discourse, and look at how the discourses of health education and health promotion have been constructed within the discursive, social and political terrains in which they are found.

This focus on language or discourse is done, as I have stated, for epistemological reasons. In preference to the referential theory of knowledge and truth, I favour a non-referential epistemology based on a performative or 'use' theory of language first put forward by the language philosophers Austin (1962) and Wittgenstein (1963). Austin's 'speech act theory' heralded the idea of language being functional and useful rather than descriptive. A discourse-user is able to use language for particular purposes or functions. Language is used to do things.

Both Sarbin (1986) and Gergen (1989) recognise that language and social construction rely on collaboration with others. We are dependent upon the willingness of others in the construction of our language and our stories. Discourses are therefore subject to social sanctioning and negotiation. Potter and Wetherell (1987) talk about people having at their disposal sets of linguistic devices, 'interpretive repertoires' that they draw upon in constructing their accounts of events. In a similar way, Gergen (1989) describes people as actors in a moral universe, concerned with negotiating for themselves a credible (and creditable) moral position through the language they use. These theorists have a view of language-users who have a measure of control over their use of language for various and particular functions within various and particular contexts. Discourse-users have at their disposal the means to manipulate discourse and use it for their own ends. The act of construction then is essentially a powerful act. By using the methodology of Foucault, I will explore this notion of discourse and power. This exploration will help to answer the question of how it is that certain discourses in health education and health promotion have become legitimate and gained dominance over others. As well, I hope to better understand who is served by such discourses, and who might, as a result, be marginalised or disadvantaged.

### ***The Challenge of Post structuralism and Post modernism***

My argument is that the epistemology of social constructionism is a radical departure from the widely held referential traditions of realism, positivism, modernism and liberalism. Instead, social constructionism has developed within another tradition, that of post structuralism and post modernism. In the following section I explore how this tradition has developed as a challenge to the two dominant paradigms, positivism and liberalism.

In many respects, the modern art movement with its focus on disintegration, anti-positivism, and anti-representationalism better expresses the ideas of post-structuralism and post-modernism, than it does modernism. Contradiction, multiplicity of perspectives and deconstruction dominate post-modern and post-structuralist thought (Grbich, 1999). For many people in today's postmodern world, grand narratives of positivism and liberalism have lost their credibility. These people have clearly lost faith in the great emancipatory narratives (Lyotard, 1979/1984). Post modernism is critical of modern society and of its failure to deliver on its promises. In light of the various horrors of the twentieth century mentioned earlier such as the holocaust, American interventionism, and Stalinist atrocities, post modernists ask how anyone can believe that modernity has delivered on its promise of progress and hope for a still brighter future. The post modern tradition, then, has developed out of a critique of Western civilisation, industrialisation and empirical science. It has done so by taking an ironic stance toward the contemporary world. Baudrillard (1990/1993) urged intellectuals to 'embrace contradictions, to exercise irony, to take the opposite tack, to exploit rifts and reversibility, even to fly in the face of the lawful and the factual'. The final part of this chapter examines in detail some of the key ideas behind post modernism and post structuralism, and explores some of the research methodologies that arise from this tradition.

My story so far has suggested a shift by some thinkers, philosophers and intellectuals away from a modern positivist paradigm or meta-narrative, to a postmodern one. This shift entails a profound epistemological shift, but includes other shifts as well - artistic, cultural and ethical. Within the broad field of health education and health promotion, I

will argue that shifts have occurred throughout the twentieth century which echo some of these moves. Health education developed during a time when the traditions of positivism and individualism were dominant, whereas health promotion emerged later, still at a time when the humanist and liberal movements were dominant, but also when post-modern ideas were emerging. Because they arose during the twentieth century, both health education and health promotion carry the ethos of the enlightenment project and modernism with them. I will examine some of the ways in which postmodern researchers are developing methods that are true to the postmodern epistemology of social constructionism. In particular, my earlier review of the thinking and methodology of Foucault prepares the way for using his methods when I come to analyse the curriculum's discourses.

### ***Post-structuralism and postmodernism***

The challenges post-modernism poses (sic) seem endless. It rejects epistemological assumptions, refutes methodological conventions, resists knowledge claims, obscures all versions of truth, and dismisses policy recommendations (Rosenau, 1992).

I have already discussed the profound epistemological shift from referentialism to non-referentialism. The development of a non-referential epistemology and social construction are two key aspects of what has been termed post-structuralism or postmodernism. Whilst both terms have been used to 'label' this intellectual movement, I concur with Ritzer (1997) and see postmodernism as a term robust enough to include post-structuralism. However, a brief 'teasing out' of the terms might help as I move to using the term postmodernism as the inclusive term.

There is a sense in which postmodernists and post-structuralists keep the ideas of modernism and structuralism close by, in view, not cast aside. Ritzer (1997) points out that poststructuralists are 'generally embedded in structuralism at the same time that they are trying to distance themselves from it'. The ideas of modernism and structuralism have had such broad-ranging impact that postmodernists and post-

structuralists see a need to keep them visible and available so as to be able to talk about them, critique them and understand how the present is contingent upon them. I acknowledge the strong hold that modern discourses have on my thinking, and agree with Dahlberg et.al.'s (1999) insight that 'we are always inside the concepts we wish to critique'. There is a tacit acknowledgement of intellectual debt, in which postmodernism and post-structuralism could not have developed without first engaging with the ideas of modernism and structuralism:

I am sure that my own debt to modernism, to its great literature and its critical theories, concepts, and methods, will be more than I know myself. I suspect too that while I have tried to present cultural history as replete with heterogeneous fragmentation, discontinuity, multiple and conflicting and contesting meanings and values, history as finally undecidable textuality, my argument probably keeps reintroducing the very notions I'm trying to oppose (Docker, 1994: xiv).

There is within postmodernist writing the paradoxical idea that postmodernism builds itself upon, but seeks to distance itself from, and question structuralist assumptions (Ritzer, 1997). This inclusion of certain structuralist ideas, but also the forceful critique of various structuralist tenets is evident in the way in which we think about or view the human subject. As we will see in Section Two, health promotion, and health education especially is interested in the health of individuals. It follows that a critique of the human subject is central to the understanding of these disciplines.

Lévi-Strauss, a leading structuralist, called the human subject the 'centre of being' (Sarup, 1993) in the sense that a modernist's interest in structures is ultimately because of the belief that these structures will be of interest to, and possibly beneficial to man. Curiously, Lévi-Strauss also stated that the ultimate goal of human sciences is not to 'constitute man but to dissolve him'. By trying to uncover the general structures that underlie human activity structuralists focus less on the human subject than do modern humanists (Ritzer, 1997). Various thinkers from both the humanities and social sciences have talked about the 'death' of the human subject. For some, like

structuralists Freud and Lacan, the subject is not actually dead but instead requires 'decentring'. For others (post-structuralists), the human subject is a 'mere construction' (Ritzer). Post-structuralists Foucault and Derrida argue that the self is only a 'position in language', a mere 'effect of discourse' (Flax, 1990). Instead of discourses constituting or producing a 'person' or a 'subject', they rather produce 'subject positions' or 'sites' (Rosenau, 1992). Foucault's position has already been discussed in Chapter One.

The death or decentring of the subject was important to structuralists as they continued the Enlightenment project. With their focus on structures rather than on the human subject, they believed they were in a better position (less encumbered) to understand those structures that dominate and pervade human experience. Structuralists of a humanist persuasion believed that such understanding would lead to an improvement in the human condition (Rosenau, 1992). Post-structuralists reject both the idea of the central human subject, but also the need to analyse and understand structures. For them humanism has failed. I have already suggested that we were led into various atrocities under the name of humanism. Though it claimed to champion justice and equality, humanism can be seen to have been used by liberal politicians to legitimise injustice and inequality. In addition, humanism has been blamed for disrupting traditional societies by introducing such 'advances' as education and Western medicine. As a consequence, traditional societies have, paradoxically, been introduced to unrealistic expectations, and to disease. They have been stripped of their unique ethnic identities and cultures. Humanist intentions and actions were driven by a belief in the importance of the human subject, in equality and social justice. However, post-structuralists argue humanism is directly responsible for undesirable and often tragic social results. This problem with humanism is raised by Lyotard (1988/1993) in the context of grand narratives. He argues that grand narratives such as humanism, inevitably leave some groups out and when that narrative is then imposed on them as it almost certainly does, disastrous results often occur.

Post-structuralism has been seen as the intellectual precursor of postmodernism (Bertens, 1995). Ritzer (1997) sees 'a flexible, quite porous line separating

poststructuralism and postmodernism' but refuses to draw the line, especially in the work of postmodernists like Foucault. I agree with Ritzer, that drawing such a line can be seen as a structuralist move, and therefore unimportant and meaningless within a postmodern way of thinking. Consequently I use the term postmodern to include post-structuralism with its rejection of structures and underlying explanations, rejection of positivist science, humanism and liberalism, as well as its subversion (Rosenau, 1992) of the human subject.

Returning to the idea that postmodernism focuses on a 'questioning' stance, I like to think that postmodernism also includes an ironic stance toward the contemporary world (Ritzer, 1997). Postmodernists, freed from the constraints of the human subject, social structures, and the humanist drive to improve people's lives, are able to take different perspectives and 'play' with a wide range of intellectual ideas. This is not new. There have been schools of thought since Aristotle which have respected skepticism, diversity and complexity. Toulmin (cited in Dahlberg, et.al., 1990) makes the point that many of the defining characteristics of postmodernism were present in early (Renaissance) modernism. Certainly, a tolerance for ambiguity, plurality or lack of certainty has been the hallmark of many thinkers over the last two thousand years of Western thought. Postmodernism picks these ideas up again and enunciates them within the context of our time.

With the rejection of grand meta-narratives, postmodernists are able to devote their attention to the edges:

What has been taken for granted, what has been neglected, regions of resistance, the forgotten, the irrational, the insignificant, the repressed, the borderline, the classical, the sacred, the traditional, the eccentric, the sublimated, the subjugated, the rejected, the nonessential, the marginal, the peripheral, the excluded, the tenuous, the silenced, the accidental, the dispersed, the disqualified, the deferred, the disjointed (Rosenau, 1992:8).

This approach is akin to Foucault's. There is a playfulness in the approach, a willingness to embrace different perspectives, even perspectives previously thought odd, strange or quirky. For Foucault, his critical genealogy takes this approach with its 'niggardly' and provocative questioning. In taking this stance or approach, truth becomes multifaceted and constantly changing. Multiple voices are heard, including that of the researcher (Grbich, 1999). For this reason, my reflexive position as researcher is important. I am present in this research, and my voice is able to be heard. This approach to research is a radical departure from positivist science where the researcher stands separate from the phenomena being studied.

For postmodernists, there is the realisation that science is nothing more than another grand narrative, a game like all other games. Wittgenstein (1963) introduced the idea of 'language games' having their own rules, being played by people who understand and use these rules within certain contexts and circumstances. Science can be viewed as one such language game. In Wittgenstein's view, those playing a language game cannot use the rules of that game within another language game; nor can they use one language game to judge or critique another. As we have seen, Foucault is concerned in a similar way to Wittgenstein with questions to do with the rules that permit certain statements to be made or unable to be made. He takes Wittgenstein's idea further, examining the way in which certain discourses become dominant, securing others within their bounds.

Postmodernists believe that what is real cannot be separated from the interpretation of it, and it is impossible to adjudicate conflicts between interpretations (Best & Kellner, 1991). Taking this view, science is no longer able to claim universal legitimacy. Instead, according to Fraser and Nicholson (1990) "legitimation becomes plural, local and immanent...there will necessarily be many discourses of legitimation...legitimation descends to the level of practice....there are no special tribunals set apart" (p.23). Lyotard (1979/1984) believed that grand narratives have suffered irreparable harm, due in part, to attacks such as Wittgenstein's language game argument and the legitimation arguments above:

There is no grand consensus but simply a consensus on the rules of a series of local games and the moves to be made in them. Thus, postmodern science is a series of local language games with heterogeneous rules involving the search for dissent in which the objective is the generation of new ideas. Instead of consensus, there is the search for dissensus (sic), for differend (Ritzer, 1997:131).

We can see, then, that postmodernism argues against meta-narratives, global world views, or master-codes. Rather than taking the modern meta-narrative stance and assume the validity of their own truth claims, postmodernists prefer the lack of truth claims in the stories of mini-narratives, micro-narratives, local narratives and traditional narratives (Rosenau, 1992). Sarup (1993) agrees with Lyotard that we can 'no longer talk about a totalizing (sic) idea of reason for there is no reason, only reasons'.

### ***Postmodern research***

Given the review of postmodernism above, postmodern research is as a consequence ambiguous and reflexive with a continual and rigorous questioning of the text (Grbich 1999). There is a resistance to reach conclusions and explanations, or to develop grand theories or meta-narratives.

Following the emergence of social constructionism and the primacy that gives to language and discourse, everything in postmodern research is defined as 'text'. With that comes interest in such ideas as intertextuality and the deconstruction (Derrida, 1991) and analysis of texts. Some postmodern researchers such as Potter and Wetherell (1987) and Parker (1992) prefer to work with text to better understand what the text 'does'. They follow Austin, Wittgenstein and the early 'archaeological' Foucault and are interested in how discourses are used to perform certain functions and purposes. Other researchers such as Derrida and the later 'genealogical' Foucault use deconstruction of text to enable a 'reconstruction of knowledge and policy; removal of status, power and hierarchy; and the construction of different, more egalitarian discourses' (Grbich, 1999:52). For such researchers the processes of deconstruction allow the emergence of new realities.

Foucault's later genealogical focus on discourse and power reflects my concern about the way in which health education and health promotion discourses can be seen as powerful tools in the subtle control of people and societies. This aspect of my research will be a focus of Section Two.



## SECTION TWO

### Analysis

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In this section I use Foucault's archaeological and (to a lesser extent) genealogical methods to focus on health education and health promotion discourses found within health education curricula. Using selected key texts, I analyse the use of, and track the changes in these discourses over the last half of the twentieth century. The most recent health education curriculum, *Health and Physical Education in the New Zealand Curriculum* (1999), overshadows this section (Chapter Three), and it is against this background and within the context of New Zealand schools that this Section is written. I do this by working backwards in time, in broadly archaeological fashion, from recent to early discourses. Chapter Three examines the health education and health promotion discourses of *Health and Physical Education in the New Zealand Curriculum* and published discourses of its principal writers; Chapter Four focusses on selected texts published since, and including, the landmark *Ottawa Charter for Health Promotion* (WHO, 1986) and the *Health Education Syllabus* (Department of Education, 1985); and Chapter Five focusses on texts written prior to the *Ottawa Charter* going back to the *Health Education in Primary Schools* (1958). This in no way should indicate that there are three archives. The division is purely a management and editorial device.

Each chapter analyses key definitions and theoretical underpinnings of health education and promotion practice extant at that time. To help make sense of the changing discourse, I introduce contextual material which forms an important part of the wide range of political, social and other contingencies operating upon the discourses under analysis.

While this section draws heavily on health education and health promotion discourses and conditions that may lie outside the experience of many New Zealand teachers, my

aim is to show that these 'outside' discourses were available to the curriculum writers at the time of drafting the document.

Chapter six re-works, or re-traces the archive, returning to the present from the past, using a more genealogical (critical) approach to the analysis. In this way this section serves to show how the use of health education and health promotion discourses by health educators working within the education system is, to some extent, contingent upon the social and political conditions of the time, especially the conditions set in place by the policy directions of the World Health Organisation.

## Chapter Three

### The current curriculum discourses

Beginning with the most recent New Zealand health curriculum, I begin the analysis of the archive.

In this chapter I explore and analyse the discourse of Health and Physical Education in the New Zealand Curriculum (Ministry of Health, 1999) and the discourses of its two principle writers. In the following two chapters I move back in time and analyse discourses that were available to the writers at the time of curriculum development.

#### The 1999 Health Education Curriculum

Early in 1999, the Ministry of Education published Health and Physical Education in the New Zealand Curriculum, a curriculum statement written to support the Health and Physical Well-being essential learning area.

In its Foreword, the curriculum is introduced by using a broadly educational discourse of knowledge, skills and attitudes acquisition along with certain desirable values such as responsibility and relationships with others:

students will gain the knowledge, skills, attitudes, and values to enjoy a healthy lifestyle... Students will take increasing responsibility for their own health...[and] will develop the skills that will enable them to enhance their relationships with other people (Ministry of Education, 1999:5).

This 'personal health education' discourse is focussed upon students and their learning. It positions the student as a learner of new knowledge, skills and attitudes as well as learning to value a particular lifestyle. Because of their professional role in the delivery of curriculum, teachers are, by this discourse, positioned as knowledgeable and skilful, (or able to access knowledge or teach skills), as well as being able to facilitate students

gaining certain attitudes and values. One of the attitudes expressed in the Foreword is that of personal responsibility for health. Coming at a time in the social and political history of New Zealand where neo-liberalism has held the political stage, this discourse of individual responsibility is a familiar one for teachers. Neo-liberal discourses of individualism, in the context of health have been widely documented (Kelsey, 1995; Labonte, 1997) supporting moves towards privatisation, and the withdrawal of central government from the provision of health services. Individuals who take responsibility for their own health, are, it is argued, less of a burden on the taxpayer. They are more likely to adopt healthy behaviours and lifestyles, more likely to take out private health insurance, and less likely to rely on the publicly-funded health system when in need.

In addition to this neo-liberal, individualistic, health education discourse, the curriculum uses a 'health promoting schools' discourse that focusses on a school's responsibility to foster student health and well-being:

In order to foster academic achievement and provide students with equal educational opportunities, schools need to address the broad health issues that affect students' learning. The health and well-being of students affects their academic achievement (Ministry of Education, 1999:5).

Unlike the previous discourse, this discourse is not aimed directly at student learning, but focuses more broadly on a school's responsibility in identifying health issues that might be affecting students' well-being, and to take whatever steps it can to attend to those issues. Identifying and addressing student well-being issues is important in the context of a school, not because health itself is important, but because learning is important. In order to foster learning, a school is encouraged to foster health and well-being.

A third 'community health development' discourse is apparent in the Foreword, where students are challenged to contribute and participate in the development of a community's health:

Students will...contribute actively to the well-being of other people and the well-being of their communities...They will... participate in creating healthy communities by taking responsible and critical action (Ministry of Education, 1999:5).

Like the first 'personal health education' discourse, this discourse encourages an attitude of responsibility. Of note though, is a move towards a health perspective that is wider than the individual. The curriculum is embracing a discourse of student involvement and activity in the health of the wider community. Where the first discourse focuses on the development of healthy personal lifestyles, and the second on individual educational attainment, this third discourse shifts the focus from the students' health and attainment to the health of others, communities and environments.

Responsibility links strongly to notions of bio-power. The encouragement of responsibility can be seen as a disciplinary technique which contributes to the management of individuals and of the social body. By encouraging students to make responsible decisions about their health and to become actively involved in the care of themselves and their communities, this discourse appeals to such notions as self-autonomy and self-governance and Gastaldo's (1997) idea of 'creating a sphere for regulated autonomy'.

Following a brief contextual section that looks at the development of the curriculum, this chapter analyses the discourse of the curriculum in the light of the three discourses identified above. Each of the discourses is described, showing how each is used, the rules that are created in their use, and how each discourse positions students, teachers and schools in the context of health. To identify each discourse, I will continue to refer to them as 'personal health education', 'health promoting schools', and 'community health development'.

### ***Development of the curriculum***

Health and Physical Education in the New Zealand Curriculum (Ministry of Education, 1999), as its title suggests, is part of a wider curriculum initiative of the Ministry of

Education. It is one curriculum document among several, and, as I have stated above, has been written to provide curriculum guidance in 'Health and Physical Well-being', alongside six other Essential Learning Areas<sup>14</sup>. A one-page description of the 'Health and Physical Well-being' Essential Learning Area appeared in the New Zealand Curriculum Framework (Ministry of Education, 1993), providing an initial discursive direction for this essential learning area (see Chapter Four). In the same year, the New Zealand Qualifications Authority established an Advisory Group for the Health and Physical Well-being learning area, chaired by Ian Culpin. He, in partnership with a member of this advisory group, Gillian Tasker, went on to develop a key association with the Ministry in the subsequent development of the curriculum statement. In 1994, the Minister of Education, Lockwood Smith appointed a policy advisory group (PAG), its main purpose being the production of specifications for the development of a draft curriculum statement. Smith was not going to be easy to convince that certain important elements of health and physical education would need to be included in the curriculum development (Lind, 2002). According to Lind, aspects such as relationships, sexuality, a bicultural focus, Te Reo Kori (a movement programme based upon traditional Māori movement patterns), a Māori model of health (hauora) and the use of the term 'holistic' were all difficult for Smith to accept.

In its first year, the PAG commissioned a literature review of the subject area, as well as drawing up the writing specifications for the draft curriculum. These specifications were based on 'best practice' and research in health and physical education. They recognised the Crown's obligations under the Treaty of Waitangi, and addressed the principles of the National Curriculum Framework (Ministry of Education, 1993). In 1995, the PAG's Policy Specifications for a National Curriculum Statement in Health and Physical Education (Ministry of Education, 1995) became a public policy document after the contract for the development of the draft curriculum had been let to the Christchurch College of Education, with principal writers, Culpin and Tasker. By early 1996, the writers, having consulted widely with various interest groups and experts in

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<sup>14</sup> The Seven Essential Learning areas are: Language and Languages; Mathematics; Science; Technology; Social Sciences; Health and Physical Well-being; and The Arts

the area, involving many in the writing and editing process, submitted the Draft Health and Physical Education Curriculum Statement (1996) to the Ministry of Education.

In 1996 there was a change of Minister, with the conservative Wyatt Creech replacing Smith. Creech slowed the curriculum development process down, so that it was not until 1997 that public consultation on the draft curriculum occurred. This consultation was coupled with the provision of professional development for those teachers involved in the consultation process, allowing teachers and members of school communities to engage with the document, and for teachers to trial the draft curriculum in schools. During and following this professional development phase, detailed and 'informed' feedback on the document was sought from teachers and from school communities. Culpin and Tasker directed one of these consultation contracts, working closely with the ministry in the re-writing of the curriculum ready for final publication in early 1999. Culpin's and Tasker's involvement throughout the curriculum development process forms one of the key conditions in the choice and use of curriculum discourses. For that reason, a crucial part of the archive to be examined later in this chapter, are health education and health promotion discourses in two academic papers published by Culpin and Tasker around the time of curriculum development.

The curriculum writers had the challenging task of utilising the discourses of three previously separate subject areas, Health Education, Physical Education and Home Economics. However, the focus of this thesis and this chapter is on health education and, more especially, health promotion discourses, not the discourses of physical education or of home economics. I do this by analysing the curriculum's usage of the three discourses enunciated in the Foreword of the curriculum.

### ***Three Curriculum discourses***

The direction for learning is established in the curriculum through its general aims. These aims are for students to:

- A     develop the knowledge, understandings, skills, and attitudes needed to maintain and enhance personal health and physical development;

- B develop motor skills through movement, acquire knowledge and understandings about movement, and develop positive attitudes towards physical activity;
- C develop understandings, skills, and attitudes that enhance interactions and relationships with other people.
- D. participate in creating healthy communities and environments by taking responsible and critical action. (Ministry of Education, 1999:7).

Each aim is expressed in a corresponding ‘Strand’<sup>15</sup>. The curriculum’s content is defined by topics (Key Areas of Learning), and the philosophical direction of the curriculum is provided by the ‘Underlying Concepts’. These will be discussed in more detail in the following sections.

#### *The discourse of ‘personal health education’*

A personal health education discourse is discernable throughout the curriculum, in the Aims and Strands, in the ‘Underlying Concepts’, the ‘Key Areas of Learning’ and in the section dealing with implementation of the curriculum:

[S]tudents will gain the knowledge, skills, attitudes, and values to enjoy a healthy lifestyle... Students will take increasing responsibility for their own health...[and] will develop the skills that will enable them to enhance their relationships with other people (Ministry of Education, 1999:5).

The first three aims and strands are a strong expression of a personal health education discourse:

Learning in [Strand A] focuses on the personal health and physical development of students...Learning in [Strand B] focuses on the personal movement skills that students develop [and ] Learning in [Strand C] focuses on students and their relationships with other people (Ministry of Education, 1999:10-11).

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<sup>15</sup> The Strands are: A ‘Personal Health and Physical Development’; B ‘Movement Concepts and Motor Skills’; C ‘Relationships with Other People’; and D ‘Healthy Communities and Environments’.

Each strand has a clear focus on the individual student, her personal health, physical development, movement skills, and personal relationships. While these three strands do ask students to consider social, community and environmental factors (eg. the students “learn to evaluate the impacts that social and cultural factors have on relationships” (Ministry of Education, 1999:10) and also to consider how they “influence the well-being of other people” (p10), they do so in the context of individual health and well-being. The fourth strand uses a personal health education discourse to a lesser extent but does encourage students to “identify physical and social influences...that promote individual...well-being” (p.11). It does, however, focus more strongly on the “interdependence of students, their communities, society, and the environment” (p.11, italics added). As such the discourse of Strand D is less focussed on the individual student and more on communities and environments.

The strands are used by teachers as an important planning device. Each strand generates Achievement Objectives at eight levels, providing teachers with clear planning goals and a framework for tracking student achievement in the Health and Physical Well-being essential learning area. As we shall see in Chapter Five, the health education and physical education syllabi that preceded this curriculum focussed strongly on personal health and physical activity, so it is not surprising that teachers see Strands A, B and C as familiar health education and physical education strands (Tuffin & Tonner, 1997), with a focus on individual students gaining knowledge, attitudes and skills in health and physical activity.

While teachers generally use the strands for setting learning goals and tracking achievement, they look to the seven Key Areas of Learning (KALs)<sup>16</sup> for the content of their health and physical education programmes. A personal health education discourse is threaded through the KALs, beginning with the introductory statement with it’s clarification of why these particular areas were chosen:

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<sup>16</sup> The KALs are: Mental Health, Sexuality Education, Food and Nutrition, Body Care and Physical Safety, Physical Activity, Sport Studies, and Outdoor Education.

The key areas of learning reflect and address the current health and physical education needs of New Zealand students (Ministry of Education, 1999:35).

During the development stages of the curriculum, there was wide concern being expressed by politicians about the “alarming rates of suicide, sexually transmitted diseases and alcohol related problems amongst New Zealand youth in comparison to other so called developed societies” (Culpin, 1996/97). Government and other interested parties clearly saw the curriculum as a key strategy for addressing these ‘current’ youth health problems.

Health education has traditionally been used in attempts to change individual health behaviour, often in response to health problems, and this curriculum is unashamedly continuing in this tradition. For instance, there is a strong emphasis on opportunities for students to develop knowledge, understandings and skills to enhance health. There is a focus on causes and effects, informed decision-making, recognition of health problems, examination of personal attitudes in relation to a range of current health issues, and strategies for minimising personal risk and harm. Presumably, these aspects of learning will prepare students to approach future (presently unknown) health issues and problems in a reflective, critical and positive manner. The KALs also have a strong emphasis on becoming physically active and participating in sport and outdoor activities. The emphasis on personal learning for health enhancement is highlighted in all the KALs as the following selections illustrate:

**Mental Health**...develop knowledge, understandings, and skills to make informed, health-enhancing decisions in relation to drug use and misuse;

**Sexuality Education**...develop knowledge about the process of conception and the skills to make decisions that maintain and enhance their sexual health;

**Food and Nutrition**...develop knowledge, understandings, and skills for selecting and preparing food and eating patterns that reflect health-enhancing attitudes towards nutrition;

**Body Care and Physical Safety**...develop knowledge and skills for the prevention of illness, injury, infection, disease, and common lifestyle disorders;

**Physical Activity**...develop movement skills for physical competence, enjoyment, a sense of self-worth, and an active lifestyle;  
**Sport Studies**...develop skills for participating in diverse sporting roles;  
**Outdoor Education**...planning strategies to evaluate and manage personal...safety, challenge, and risk (Ministry of Education, 1999:37-47).

The Underlying Concepts of the curriculum<sup>17</sup>, in the main, attempt to place personal health within wider contexts and conceptual frameworks. Personal health is discussed within the concept of 'well-being, hauora' where its scope is identified as encompassing 'the physical, mental and emotional, social, and spiritual dimensions' of a person<sup>18</sup>. Within these parameters, personal health education is focussed upon the individual, her physical, psychological (including mental, emotional and spiritual) and social self. While the concept of 'well-being, hauora', as enunciated in the curriculum, and emphasises the individual by defining such dimensions, the other underlying concepts also include some aspects of personal health discourse. For example, the underlying concept 'health promotion' includes the development of "personal skills that empower [students] to take action to improve their own well-being" and "encourages students to make a positive contribution to their own well-being" (Ministry of Education, 1999:32); the 'socio-ecological perspective' suggests that students should "identify and reflect on factors that influence people's choices and behaviours relating to health and physical activity"; and "programmes in health and physical education contribute to the well-being of individuals...by promoting [a list of] attitudes and values" (ibid.:34).

The discursive rules for using this personal health education discourse include an emphasis on the individual, and their learning certain knowledge, attitudes and skills that will enhance their health and well-being. The individual is expected to become engaged in making informed decisions regarding their health, and to place positive

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<sup>17</sup> The Underlying Concepts are listed as: well-being, hauora; health promotion; the socio-ecological perspective; and attitudes and values that promote hauora.

<sup>18</sup> This is a generous interpretation of the script. The curriculum actually states that "the concept of well-being encompasses the physical, mental and emotional, social, and spiritual dimensions of *health*" (p.31, italics added).

value on health and well-being. Prevention of current health problems is a clear agenda of the discourse.

This personal health education discourse was being subjected to challenge during the period of curriculum development. In the following chapters, some of the challenges will be discussed and analysed, providing insight into why it is not the sole discourse of this curriculum. It does, however, remain a key discourse, supporting neo-liberalism in its moves to empower individuals to take responsibility for their own lives and health, and reducing the state's responsibility to provide health services for people who may suffer from preventable health problems that occur because of a person's poor (but informed) health decisions (Short, 1999).

#### *The discourse of 'health promoting schools'*

In order to foster academic achievement and provide students with equal educational opportunities, schools need to address the broad health issues that affect students' learning. The health and well-being of students affects their academic achievement (Ministry of Education, 1999:5).

This discourse is built on the premise that the higher the standard of health a student enjoys, the higher her standard of academic achievement is likely to be. This idea has been held as self-evident by many, both in health and in education. Evidence in support of the claim has been provided by epidemiological data showing positive correlations between health status and academic achievement (Short, 1999). Labonte (1997) draws on the work of Blane, White & Morris (1996) in suggesting that the relationship between education level and health is explained by a more general experience of 'deprivation' or a pervasive pattern of living in conditions of risk, than by academic achievement alone. Other evidence suggests positive correlations between powerlessness and ill-health (Evans, Barer & Marmor, 1994), and between poverty and other measures of social inequality (including educational opportunity and attainment) on health, both for individuals and for whole populations (e.g. World Health Organisation, 1984; Marmot and McDowall, 1986; McIntyre, 1986; Gustavesen, 1988;

Evans and Stoddart, 1990; Smith, Bartley and Blane, 1990; Townsend, 1990; Marmor, Barer and Evans, 1994; Blane, Brunner and Wilkinson, 1996; Wilkinson, 1996).

There is little in the Foreword of the curriculum that would indicate how the curriculum might link with the Health sector initiative 'Health Promoting Schools'. The statement is simply a challenge to schools to become committed to addressing broad health issues that affect students' learning.

So how have schools taken up this challenge? In Chapter Four I outline the initiatives that have occurred in New Zealand, to establish a movement that would encourage and support health promoting schools. The discourse used by the health promoting schools movement was, I argue in the next chapter, a key discourse available to the Ministry of Education and the curriculum writers. The health promoting schools movement has occurred in the main outside education, driven instead by the health sector. As such, it has not focussed on school curricula, nor on health education discourse, to further its aims. However, Health and Physical Education in the New Zealand Curriculum can be seen (in its most generous light) as a Ministry of Education attempt to support the health sector initiative, by harnessing the teaching workforce and using teachers as agents of the health promoting school movement. This aim is furthered through the use of a health promoting schools discourse throughout the curriculum, thereby exposing the teaching profession to wider health promotion discourse and philosophy. In addition, exposure to such discourse opens up possibilities for health promotion action that would have been impossible without access to these ideas and ways of talking.

A second way of addressing the curriculum's challenge unfolds in the discourse that suggests using students as active participants in the creation of health promoting schools through their health and physical education programmes. By stating that "the health promotion process requires the involvement and collective action of all members of the wider school community [including] students" (Ministry of Education, 1999:32), the curriculum sets the stage for students to learn how to become involved and active in improving school health. According to the curriculum, they will learn these

understandings and skills whenever they are involved in their health and physical education programmes.

This discourse of student involvement in health promoting schools can be found throughout the curriculum. As one of the Underlying Concepts, health promotion is defined as “a process that helps to create supportive physical and emotional environments in classrooms, whole schools, communities, and society” (Ministry of Education, 1999:32). Health promotion “encourages students to make a positive contribution to [the] well-being of...their communities and environments” (ibid.). The curriculum gives students and teachers clear guidance on how to engage in health promotion:

By engaging in health promotion, students and teachers can:

- come to understand how the environments in which they live, learn, work, and play affect their personal well-being and that of society;
- develop the personal skills that empower them to take action to improve their own well-being and that of their environments;
- help to develop supportive links between the school and the wider community;
- help to develop supportive policies and practices to ensure the physical and emotional safety of all members of the school community (ibid.).

The curriculum cites the Ottawa Charter for Health Promotion (WHO,1986) for the process described above. The charter, discussed in more detail in Chapter Four, has been used as a base document for health sector health promotion in New Zealand since the late 1980s. Its appearance within a 1999 school curriculum document is of interest in the light of this thesis. In Chapter Four, I attempt to show how this health sector document has spawned a health promotion discourse widely used and practised by health sector health promoters and public health professionals for over a decade. It’s use within an education sector document has demanded it be re-worded for a teacher audience. As well, it is a contingency at play in the shifting of student learning from an emphasis on the self to others, communities and environments. Not only are students

encouraged to understand how environments affect health, they are also urged to develop skills and strategies to contribute to making those environments healthier. What was once the domain of school management and teachers, now also becomes the domain of students. At every level of the school, from new entrants to senior secondary levels, students will be learning ways of making their immediate environments more conducive to health and well-being. The health promoting school discourse focusses teacher and student attention on one such immediate environment, the school. As such, it recognises the links a school has with the wider environment and wider community, but suggests students learn health promotion skills within the familiar setting of their own school.

The health promoting schools discourse is supported by carefully-chosen attitudes and values which are to be promoted through health and physical education programmes. There is an assumption that health promotion action will be strengthened through 'valuing other people; a willingness to reflect on beliefs; integrity, commitment, perseverance, and courage; respect for the rights of other people; acknowledgment of diverse viewpoints; tolerance, rangimārie, and open-mindedness; care and concern for other people in their community and for the environment; co-operation and āwhina; care, compassion; constructive challenge; positive involvement and participation; and a sense of social justice' (selection from p.32). Such attitudes challenge students to draw upon their own personal integrity and perseverance in promoting health in the school. In addition, students are challenged to develop attitudes such as concern for other people and to value such positions as positive involvement, positions that are more likely to lead towards motivation to become involved in community action.

Whenever values and attitudes are highlighted within the curriculum, one is again reminded of Foucault's discussions of disciplinary power and his idea of self-regulation. As I said in Chapter One, Foucault's concept of power is expressed in the way it 'disciplines, shapes or coerces people by getting people to self discipline and regulate their behaviours and actions'. The health education curriculum serves as an example of how power is manifest in the way in which people take on the personal responsibility to be 'good' or 'healthy' social subjects. If teachers are successful in

inculcating such attitudes in their students, they will, it is hoped, be less reliant on outside regulatory bodies such as the police or health inspectors to maintain a healthy populace.

In the introductory statements for each KAL, there is a reminder to teachers about the importance of the school having policies and practices in place that support that particular KAL. Presumably this reminder is aimed at encouraging teachers to involve themselves in the process of ensuring such policies and practices are in place, audited and reviewed. This is, for many teachers, a sizeable departure from their perceived or traditional classroom teaching role (Tuffin & Tonner, 1998). In a few of the KAL introductory statements, teachers are encouraged to involve students in the work of improving practices within the school and wider community. Learning opportunities that encourage students to become involved in promoting health in the school setting are provided with some KALs as these selections indicate:

**Mental Health**...responding constructively to discriminatory practices and behaviours; working co-operatively to achieve common goals in a range of settings; managing change, implementing practical strategies for supporting other people; becoming aware of policies and laws (eg. in relation to drugs, abuse, harassment).

**Body Care and Physical Safety**...develop the ability to identify environmental hazards, such as hazards near roads, in playgrounds, and risks relating to fire, sun, and water; develop attitudes and values that encourage them to take responsibility for [the] physical well-being of other people and to care for the environment.

**Physical Activity**...develop actions in physical activity settings including care for the environment, and a willingness to become involved (Ministry of Education, 1999:37-43).

Given the key role of KALs in defining the content of the curriculum, there would be an expectation that student involvement in contributing to their school's health environment would be a strong feature of each KAL. Curiously, however, this is not the case. Instead, its strongest expression occurs within Strands and the lists of

Achievement Objectives (AOs) at most levels. In particular, Strand D - Healthy Communities and Environments, through many of its AOs at all eight levels, gives a clear indication to teachers, that students will become involved in promoting health within the school setting. For instance:

**Level 1, Strand D, AOs 1 and 3 - Societal Attitudes and Beliefs - Rights, Responsibilities, and Laws:** Students will take individual and collective action to contribute to safe environments that can be enjoyed by all;

**Level 3, Strand D, AO 3 - Rights, Responsibilities, and Laws:** Students will research and describe current health and safety guidelines and practices in their school and take action to enhance their effectiveness;

**Level 3, Strand D, AO 4 - People and the Environment:** Students will plan and implement a programme to enhance an identified social or physical aspect of their classroom or school environment;

**Level 7, Strand D, AO 2 - Community Resources:** Students will advocate for the development of services and facilities to meet identified needs in the school (Ministry of Education, 1999:14-27).

The Underlying Concept 'The Socio-ecological Perspective' states that:

people can take part in the health promotion process effectively only when they have a clear view of the social and environmental factors that affect health and well-being. Through learning experiences [students] can help to create the conditions that promote their own well-being and that of other people" (Ministry of Education, 1999:33).

Such learning will be evident "when students actively contribute to [the] well-being...of other people and society, and to the health of the environment that they live in" (ibid.).

This health promoting schools discourse positions students as change agents within their school setting. It places them in a position where they are encouraged by their teacher (through the curriculum) to research health policies and actions in their school and become actively involved in making changes to these policies and actions. This

positioning has the possibility of putting students in some rather difficult power relations with adults, especially those in management and administrative roles within the school. Where students are asking questions and seeking information that may uncover weaknesses in the school's health policies or actions, or expose personnel and systems as wanting. This may lead to students making judgements about adults who have previously been viewed as authority figures. They may become suspicious or critical of staff, Board of Trustees members, parents and others associated with health in the school. They may find, for instance, that there are no or inadequate written policies, or they may suspect the school does not value health very highly. They may begin to suspect the principal, for example, as a barrier to health promotion in the school, thus undermining her/his authority and respect. In addition, students may be met with negativity, rebuffs or even abuse from adults as they go about their assignments. Unless the classroom teacher has foreseen these possibilities and worked through the organisational details, such as forewarning key adults about what the students will be doing during their health education lessons, and providing professional development for staff and BOT members, students may well be placed in positions of harm. The ethical consequences of placing students (and adults) in such positions may well lead to suffering or harm as the result of this (curriculum) process.

The process of preparing students to become change agents thus requires a range of preparatory responses from teachers. They need to carefully prepare the students for their research, planning and actions. They need to ensure that all adults are adequately prepared for students asking questions about the running of the school. They need to enter into professional ethical planning to protect the students and adults from harm or suffering. These teacher responsibilities position teachers differently from the traditional classroom curriculum delivery role. They are as a result positioned as 'ethics committee', 'professional developer' and 'adult educator', 'negotiator' and 'organiser' of staff and BOT members. It is little wonder that in my recent role as school Health and Physical Education Adviser, very few teachers were prepared to take on this role, admitting they are not fully implementing Strand D as a result.

On the surface, the idea of involving students in improving health within the school seems laudable. It draws on notions of empowerment, participation in health, and active involvement, all strongly advocated in the curriculum's discourse. However, unless such processes are well planned and fully supported by the school's management and administrative personnel, the curriculum may well be seen as 'disciplining' these personnel and pressuring them through shame or through ignorance to make health changes in the school. In this way the curriculum can be seen as device of disciplinary power, using children to change the practices and attitudes of adults who hold positions of power in the school.

The discursive rules for the use of 'health promoting schools' discourse centre around the idea that students' learning will be improved through the provision of a 'healthy' environment, and that teachers and students need to work towards developing such an environment. The teacher is positioned as facilitator of student involvement, encouraging students to think of health being determined not just by the decisions we make about our individual health behaviour, but by the environments and conditions we live and work within. Students are positioned as having agency and the ability to make significant differences to the environmental conditions for health. The third discourse (below) is similar, but differs with its emphasis on the wider community rather than the (narrower) setting of the school.

*The discourse of 'community health development'.*

Students will...contribute actively to the well-being of other people and the well-being of their communities...They will... participate in creating healthy communities by taking responsible and critical action (Ministry of Education, 1999:5).

Given the opportunities students have to practice health promotion within the context of the school ('health promoting schools' discourse), the curriculum takes this challenge further by calling on students to become involved in wider community health development. I acknowledge that this is one interpretation of the above quote, and that

it could be interpreted by some to refer to the school community only. However, there are examples within the curriculum indicating that student involvement and active contribution to wider community development is expected as an outcome of learning in this essential learning area. Again, some selected examples from the curriculum confirm a discourse of student action in community health development:

**General Aim D:** for students to participate in creating healthy communities and environments by taking responsible and critical action;

**Strand D:** Students are encouraged to make changes and contribute positively through individual and collective action, to the development of healthy communities and environments;

**Level 4, Strand D Achievement Objectives 3 and 4:** Students will specify individual responsibilities and take collective action for the care and safety of other people in the wider community;

**Underlying Concept Physical Activity:** Students will be encouraged to work towards improving practices relating to physical activity within the wider community (Ministry of Education, 1999:7,11,21,42).

The creation of healthy community environments and responsibility for acting in the interests of people in the wider community are suggested as legitimate activities for students while involved in learning programmes in Health and Physical Education. The curriculum discourse takes students out of the classroom, away from a focus on their own personal health, and into the school environment, and the wider community environment. They will, through a socio-ecological perspective be taught about the relationship between health and society, and between health and environments.

As with the 'health promoting schools' discourse, this discourse positions teachers outside their traditional role (Tuffin & Tonner, 1998). Understandably, many feel inadequately prepared to teach students these skills, or unable to consider or face the ethical challenges of taking students into the wider community to affect change. Given the huge workforce development initiatives that have occurred recently in the public health workforce, moving them from health education to health promotion models of delivery, and the effort required to make such a move, it is understandably a very real

concern for teachers. Tuffin and Tonner found that the planning and delivery of classroom health education programmes are within the 'comfort zone' of most teachers, but resistance is expressed when teachers are asked to act as change agents within the school setting. This resistance is more sharply felt and enunciated when teachers are asked to act as change agents in the wider community.

So what purpose or work is this discourse doing? Is it designed to strengthen community development initiatives, resist the discourse of neo-liberalism and erode the power of that discourse? Certainly, with adequate workforce development for teachers, and with sufficient resourcing and systemic support, teachers could begin to teach and model community empowerment strategies that challenge individualistic, liberal philosophies.

### ***Other discourses***

Given the discourses discussed above, it is not surprising that the curriculum is widely held by teachers to be 'holistic' (Tuffin & Tonner, 1998), even though, following Smith's rejection of the term, it is never used in the curriculum statement. Models of holistic health rest on the idea of an integrated, interrelated, balanced whole, often with the person at the centre, but not necessarily so (eg. the earth can be viewed as the centre as with the 'Gaia' hypothesis (Lovelock, 1991;1995). So how is it that teachers read a holistic discourse in the curriculum?

A model of health is provided in the Underlying Concepts which, to most teachers (and to its author, Mason Durie) is seen as a holistic. However, the curriculum does not use the term 'holistic' in the exposition of Durie's model. Rather it is explained in the language of well-being and hauora. Hauora is, in the language of the curriculum, "a Māori philosophy of health unique to New Zealand. It comprises taha tinana, taha hinengaro, taha whānau, and taha wairua" (Ministry of Education, 1999:31). These Māori terms correspond in English to 'physical well-being, mental and emotional well-being, social well-being, and spiritual well-being'. They are 'dimensions of hauora' and 'influence and support each other'. The model is referred to as the whare tapawhā (Durie, 1994) or the four-sided house, where each of the four walls (or dimensions) "are

necessary for strength and symmetry” (1999:31). This aspect of the curriculum has been strongly emphasised in professional development programmes in support of the curriculum, and is readily understood and accepted by teachers (Tuffin & Tonner, 1998). Given teachers’ perceptions that the *whare tapawha* is a holistic model of health, its four dimensions serve to limit the extent of the ‘whole’ by emphasising personal dimensions of health, thus placing the individual at the centre of the model. This is consistent with the emphasis in the curriculum where personal health education discourse and its emphasis on the individual, drives three of the four strands.

It could be argued that this limitation of ‘holism’ to the person is based on educational knowledge of the developmental levels of young people as they move slowly and (sometimes) painfully from the egocentric to an awareness of their place within a larger, dynamic whole. However it could also be seen as an ideological move, or as a move by the curriculum developers to gain the support of a minister whose ideology was neo-liberal. The neo-liberal ideology espoused by successive New Zealand governments leading up to the publication of the curriculum revolves around the individual, her wants and goals. Such an ideology, it can be argued, is supported by models such as the *whare tapawhā* which place the individual at the centre.

However the inclusion of strong non-individualistic, health promotion discourses (health promoting schools and community health development) echoes the challenges to this neo-liberal ideology that have been mounted by health promoters in recent years (WHO, 1986; Labonte, 1997) (See Chapter Four). The inclusion of a socio-ecological discourse in this curriculum stands in resistance to the dominance of neo-liberal discourses that underpin the National Curriculum Framework, (O’Neill, 2002). However, I suggest that its impact is weakened by the particular choice of holistic model, the *whare tapawhā*, with its emphasis on the individual and dimensions of personal health, and the focus in three of its four strands on individual health attainment. This theme will be further discussed and analysed in the following chapters.

In addition to the curriculum discourses, we have the voices of the two principal curriculum writers, Ian Culpin (Physical Education) and Gillian Tasker (Health

Education) writing at the time of the release of the Draft Health and Physical Education Curriculum Statement (1996). In two key articles, Culpin and Tasker examine the development of the curriculum, enunciating health education and health promotion discourses in the process. The discourses in these two articles provide a rich discussion of some of the philosophical, epistemological, pedagogical and political issues that were upper-most for them during the curriculum development phase. As well, we see the way in which the writers are using health education and health promotion discourses, allowing an analysis of the rules they were employing in the use of these discourses.

### **The discourses of the curriculum writers**

In their discussion of the process of curriculum development (already outlined briefly above) both Culpin and Tasker discuss the political context against which they were writing. This includes both the wider political context, and the educational ‘reforms’ that they saw as linked to the political directions of the time.

#### ***Political context: New Right vs. liberal humanism***

Culpin (1996/97) discusses “how changes underpinned by New Right philosophies...have influenced these curriculum developments” (p.204). ‘New Right’ philosophies had been promoted by the incoming Labour government of 1984, promulgating an “orientation to the demands of the market economy and international competitiveness” (ibid.). Culpin saw this Treasury-led economic and social agenda as promoting “individual responsibility, a reduction in state spending and labour costs and the implementation of competitive mechanisms in all areas of the state and civil society in order to promote increased productivity” (ibid, pp.204-5). This agenda created tensions and challenges for the curriculum developers, as they manoeuvred their way between satisfying the direction of governments wedded to New Right policies, while maintaining the ‘integrity’ and survival of the health and physical education subject areas, both of which have been built upon liberal humanist values.

Political commentators were providing analyses of the social effects of such market driven policies. Peters et al. (1994) saw the so-called ‘New Right’ rising in response to

opposition towards the welfare state, claiming that it makes people dependent rather than liberating them, “increasing rather than reducing the level of material and psychological dependency among recipients, and stifling of rather than encouraging a self-help philosophy and community initiative” (p.252). They provide a clear description of New Right ideology as being:

made up of two major elements: a neo-liberal element, which is committed to the free-market and to the substitution of market-like arrangements for the state; and, a neo-conservative element, which is committed to fundamentalist and conservative moral values. These elements are united by the belief that state intervention to promote egalitarian social goals has been responsible for the present economic decline, and has represented a violation of individual rights and initiative. From this combined view, the New Right believes that equality and freedom are incompatible and that freedom construed in individual and negative terms (i.e. freedom from intervention) is indispensable for economic vitality and wellbeing (sic). The theoretical underpinnings for this view are to be found, in part, in a contemporary rejuvenation of classical liberal economic theory which privileges both the market as an institution above all others, and market values over all other value (ibid.).

This (New Right) view sees economic and social intervention as a ‘fundamental threat to individual political and democratic freedom’ (Peters et al.). With a National government in power espousing both neo-liberal and neo-conservative positions, Culpin and Tasker show a clear awareness of the tensions involved in satisfying both factions, while at the same time ensuring that liberal humanist egalitarian social goals were not lost:

(A)ddressing issues of inequity, emphasises the centrality of political action and individual and community empowerment for effective health education. This represents a major discursive challenge to an enterprise-based market economy which is underpinned by, and promotes, a model of the individual as asocial and personally responsible (Tasker, 1996/97:196).

Jesson, (1989) in a critique of these (New Right) individualistic, market-driven policies, argued that the 1984 Labour government's:

policies of deregulation and commercialisation had a multiple effect. They fostered a mood of acquisitive individualism, and a corresponding decline of social responsibility. And they undermined the economic and social basis of the country's sense of community (p.153).

He, like Kelsey (1997) saw a loss of social cohesion being one of the main costs of such policies. Kelsey notes that the mission of the new right change agents was not to 'secure socially acceptable outcomes' in the short term, believing that these outcomes would be achieved in the long term as the result of their market-driven policies. Kelsey observes that the change agents "remained oblivious to the impact of an individualised, privatised and internationalised society on human development, cultural identity and the sense of belonging to a community that cares" (p.11).

Certainly, the Ministry of Education in the New Zealand Curriculum Framework (1993) enunciates this shift away from a liberal humanist ideology of 'community care' which had prevailed in the late 1970s and early 1980s to the 'technocratic ideology' of the late 1980s and early 1990s. As the curriculum framework states, "If we wish to progress as a nation and to enjoy healthy prosperity in today's and tomorrow's competitive world economy, our education system must adapt to meet these challenges" (1993:1).

Peters et al.(1994) suggest that this shift has seen a "transformation of the language of educational discourse from one focused (sic) on the notion of equality of opportunity to one emphasising technical notions of efficiency and consumer choice" (p.260).

Peters et al.(1994) and Marshall (1994) saw The New Zealand Curriculum Framework (1993) as an attempt to 'deconstruct a nation's dependence on welfarism' (Peters et al.) and to develop an enterprise culture. They saw 'busnocratic' values from the world of work such as efficiency, enterprise and competition in the Framework's principles and in its implementation structures. However, as Peters et al. point out, citing Nash

(1989), there is evidence that policy documents which were emanating from government departments (other than Treasury) from 1984 were attempting to marry elements of market liberalism with more traditional liberal humanist concerns for equality of opportunity, equity, community participation and even more left-wing concepts such as 'empowerment'. This subtle marrying of New Right ideology with liberal humanist philosophies is also evident throughout the NZ Curriculum Framework, providing curriculum developers such as Culpin and Tasker with some room to ensure liberal humanist ideals were included alongside marketisation in the curriculum.

Tasker (1996/97) is concerned with the challenges that marketisation poses to this curriculum development:

A critical challenge for the developers of this curriculum was to establish, and incorporate, the contemporary dimensions of health education in the draft statement which would enhance the health of all students as opposed to some. In the current context of education marketisation, the primary challenge for health educators will be the retention of these dimensions (p.187).

She sees marketisation as a possible threat to the preferred approach of the curriculum. She is also concerned about the need to ensure equity through the inclusion of 'contemporary dimensions of health education' in the curriculum. These dimensions are discussed later.

Kelsey (1997) in her exposé of neo-liberalism, self-interest, opportunism, individual freedom and liberty, suggests that Treasury was not averse to "well-designed policies [that] align individual self-interest with the common interest [and that] government does have responsibilities beyond those of individuals and must pursue all the objectives of efficiency, equity, liberty, public morals and human dignity." (p.61). The task of marrying individual self-interest with the common interest is taken up by Culpin and Tasker in their discussions around two opposing approaches (or 'dimensions') to health and physical education: 'healthism' and a 'socio-ecological' perspective.

### ***Healthist vs Socio-ecological approaches***

In the context of a discussion about the place of physical education within the wider curriculum, Culpin notes that the:

release of the Policy Specifications for a National Curriculum Statement in Health and Physical Education (Ministry of Education, 1995) were met with considerable interest by scholars as it was assumed that physical education would be redefined into a health consciousness perspective embodying a strong healthism focus. This...threatens both disciplines' integrity because the prime function of the curriculum as health consciousness, of course, would be to satisfy the needs of capitalism (Culpin, 1996/97: 216).

His discussion about the integrity of health and physical education raises the issue of the best approach to take in order to satisfy health educators and physical educators rather than 'the needs of capitalism'. His linking of such ideas as healthism, a health consciousness perspective, and capitalism is part of a strategy taken by Culpin (1996/97) and Tasker (1996/97) to discredit the individualistic 'healthist' approach in favour of Lawson's (1992) 'socio-ecological' approach to health and physical education. Tasker uses Crawford's (1980) definition of healthism which identifies the individual, his behaviour and lifestyle, as the major determinant of personal health. Culpin, citing Colquhoun (1990), observes that this leads to an emphasis on self-control and self-responsibility which in turn "can lead to tremendous feelings of guilt, personal inadequacy and failure" (Culpin:214). He adds that such feelings are generated by moralists with a 'point the finger' mentality. Tasker links healthism with the "dominant approaches to health education employed through the 1970s and early 1980s [which] were based on a medicalised disease-prevention view, often delivered to students by health professionals devoid of teaching skills and any personal knowledge of their pupils" (pp.187-88). She believes that this approach to health education promotes the "eventual adoption of particular health behaviours for the purposes of preventative health care" (ibid, p.189). She goes on to suggest that those in power have used health education in this way to manage public health crises such as the AIDS epidemic, or as a strategy of capitalism to reduce the cost of health care by:

shifting the focus of treatment from centralised, and frequently expensive, technology-laden, curative medical procedures onto (sic) the individual. Deinstitutionalisation and community-care policies throughout all sectors of the health system are now widely known examples of the extension of this kind of logic i.e. the transfer of responsibility for health and welfare from the state to the community and the individual (ibid).

Tasker continues the attack on healthism by suggesting that along with individualism, healthism ‘fits well with the philosophy and practice of a market driven society’. She cites various studies (Kickbusch,1980; Naidoo, 1986; Baumann, 1989; Combes, 1989; Colquhoun, 1990; and Green & Kreuter, 1990) which indicate the failure of healthism and individualistic health education approaches in addressing the health needs of many people, especially those who are socially disadvantaged.

Having linked market-driven policies, individualism and capitalism to healthism and traditional (ineffective) health education approaches, Culpin (1996/97) and Tasker (1996/97) set about constructing an alternative approach based on addressing “health issues in relation to their causal antecedents, those based in the socio-environmental contexts in which...children live and develop” (p.189). While these causal antecedents are not listed, ‘broad pre-requisites for health’ are listed: peace, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.

Culpin (1996/97) and Tasker (1996/97) put forward the argument that health and physical education are able to make ‘wider social contributions’ through the adoption of a socio-ecological perspective. Their enunciation of a socio-ecological discourse is an important one, given the eventual placement of the perspective in the underlying concepts of the curriculum. Culpin openly outlines how this socio-ecological perspective was protected against the arguments of the monetarists through a regime of ensuring a small cabal of curriculum developers were strategically appointed to all key curriculum development committees and contracts, thus guaranteeing “a consistent and coherent philosophical base upon which to build” (1996/97:212).

Culpin sees the 'politicisation' of health and physical education and "acknowledges the socio-political forces which underlie and shape our curriculum area and our education system" (1996/97:209). He draws upon the work of Jewitt (1994) and Ennis (1992) in enunciating the philosophical and epistemological position which, he says, underpinned the development of the curriculum:

In curriculum development, there are three important considerations to be taken into account: the subject matter content, the nature of individuals who will use the content and the goals of the society whose purposes schools are trying to serve (Jewitt, 1994; Ennis, 1992). The integration of these three considerations provides developers with a range of curriculum perspectives upon which developments can proceed in an educationally coherent manner. The perspective adopted was that of "socio-ecological integration" (Jewitt, 1994) which attempts to balance priorities between the extremes of individual and global (societal) concerns. This perspective is based on the assumption that the individual is unique and is in the process of continual change as a quest to achieve full personal integration in a changing environment (Culpin, 1996/97:210).

This is a clear statement on the socio-ecological position. The discursive rules for using socio-ecological language include the provision of the view that the individual is unique, having their own 'nature', with individual concerns, and with the ability to learn subject matter content. In addition the discourse places the individual in a changing environment, interacting with and integrated into this environment. Socio-ecological discourse attempts to achieve a balance on a continuum between the concerns of the individual and wider, global concerns (reduced to societal concerns by Culpin).

Citing Sage(1993), Culpin (1996/97) bemoans the way in which physical education has not related itself to 'the power structures and social and economic forces underlying wider society'. He believes physical educators should "begin to move from a performance pedagogy orientation to one where all dimensions of physical education, placed within their wider context, are addressed in a socially critical manner"(p.210). The use of 'socially critical' will be discussed later. However, just as Culpin discusses

the need to move physical education from an individualistic pedagogy (performance orientation) to a socio-ecological one, Tasker (1996/97) discusses the need to develop effective models for school health education based on the recognition that “major health gains [are] linked not so much to advances in medical knowledge but, rather, to increases in wages and living standards coupled with improvements in public health services and health oriented legislative requirements” (p.189). She believes that the Ottawa Charter was pivotal in enunciating this position, and suggests that:

recent health-focussed curriculum models such as Jewitt’s (1994) “ecological integrative perspective” and Lawson’s (1992) “socio-ecological conception” of health also advocate these kinds of interlinked requirements. They place emphasis on the importance of addressing the personal, interpersonal, and societal aspects of health and on recognising the complex inter-connections between individuals and the environment (p.190).

One way of looking at Lawson’s socio-ecological perspective is to think of it as one end of an ‘individual - global’ continuum. Lawson’s concept sits close to the ‘global’ end, especially as it includes (in its original exposition) ‘natural-environmental contexts’. However, Lawson uses a discursive device which both Culpin (1996/97) and Tasker (1996/97) also use, that has the effect of minimising the ‘wide global’ in favour of ‘human ecosystems’. The device shifts the discourse at the global end of the continuum by variously labelling it ‘global’, ‘environmental’ or ‘societal’, but increasingly favouring human contexts (‘societal’) at the expense of ‘global-environmental’. Tasker uses the device in the following discussion on the socio-ecological perspective, saying that it

requires balance and integration between individual and societal considerations. It encourages self-reflection, critical thinking and critical action. It is designed to remove barriers to total or holistic wellbeing (sic) through the empowerment of individuals and communities to create societal conditions conducive to health for all (p.190, italics added).

Not only does this device shift the discourse, it has the effect of de-emphasising the importance of environmental health discourse by progressively narrowing socio-ecological discourse from the wider 'global' and 'natural-environmental' to the narrower 'societal', 'social-environmental' and 'community'. Tasker's socio-ecological discourse is developed around this emphasis on social processes and relationships (rather than broader environmental) conditions. Given this, it is easy to see how the curriculum's Strands reflect this focus on human environments and groupings, or the 'wider social context' and reduces the opportunity for students to consider their health and well-being in the context of global ecological forces and contexts. This is critical when seen against the subsequent curriculum emphasis on social and relationships skill development, and the devotion of one strand, Strand C, to 'relationships with other people'. As well, Strand D emphasises 'social processes and relationships' with three of its four achievement aims devoted to 'societal attitudes and beliefs', 'community resources', and 'rights, responsibilities, and laws' with only one Achievement Aim encouraging a wider understanding of physical environments. In addition, Strand B has an achievement aim which looks at the influence of 'social and cultural factors' on people's involvement in physical activity. It is of interest to note that a similar shift seems to have occurred in the curriculum's use of Durie's holistic model of health. The original model included the dimension of the significance of te whenua (the land) in addition to physical, mental, social and spiritual thus opening up the possibility of a broader understanding of holism.

Environmental education ('about, in and for the environment') has struggled for a place in the curriculum framework. It does not have its own curriculum statement, but instead appears in one aspect or another in several curriculum statements (Chapman, 1999): in the Science curriculum (with an emphasis on **about** the environment); the Technology curriculum (exploration of the impact of technology on the environment); the Social Studies curriculum (understanding people's interaction with the environment); and in the Health and Physical Education curriculum as one of the Achievement Aims in Strand D, and also (minimally) in the Key Area of Learning (KAL) Outdoor Education:

**[Strand] D4 People and the environment:** understand the interdependence between people and their surroundings and use this understanding to help create healthy environments” (Ministry of Education, 1999:9)...

**[KAL] Outdoor education** provides students with opportunities to...protect and care for the environment (ibid.:46).

However, rather than using the socio-ecological perspective to support and develop strong environmental education within the health and physical education curriculum, the socio-ecological perspective is used to support the empowerment of students and communities to “create societal conditions conducive to health for all” (Tasker,1996/97:190). This is done by drawing links between the socio-ecological perspective and post-modern curriculum theory which emphasises ‘self-reflection, critical thinking and critical action’ (Doll,1989).

### ***Self-reflection, Critical Thinking and Critical Action - Post-modern curriculum theory***

Tasker (1996/97) believes that the socio-ecological discourse (above) of interrelatedness and interdependency between individuals and their environments, ‘fits well’ with post-modern curriculum theory. In attempting to address the “antecedents of health issues and problems which have their locations in socio-cultural, historic or economic factors as opposed to individualised actions, contexts or situations” (p.192), she finds in post-modern curriculum theory, a theory that recognises the complexity of the socio-ecological stance, as well as providing support for curriculum development that addresses social change:

A post-modern health education curriculum would thus enable a school community to participate in an ever-changing society for the improved health and welfare of all its members, not just its children. Such a curriculum would need to adopt a critical analytical approach. It would be emancipatory, in that it would engage us as learners and teachers in a pedagogy through which we come to understand the social processes and relationships that dominate our practices and structures (e.g. the way we teach and learn health education) (ibid.:193).

Drawing on the work of Sage (1993), Culpin argues that a socially critical perspective allows teachers to see how their health and physical education practices are socially constructed by particular interests. He suggests that the curriculum should promote critical questioning, thinking and reasoning skills so that teachers and students “question existing social practices and the social order” (1996/97:211). He refers to the work of Colquhoun (1990), and Tinning et al. (1993) arguing that healthist, individualistic traditional physical education programmes:

rarely articulate the inter-relatedness of such concepts as body use, body care, body shape, body image, substance use and abuse, sexuality, skill and health related fitness development, elite performance, illness, disease and life span development. Further more, it is rare indeed for physical education practitioners to acknowledge and interrogate these as social constructions which are gender, race, culture and class specific (Culpin, 1996/97:214).

Tasker was also encouraged to note that such a critical approach was espoused in the Ministry of Education’s Policy Specifications for the Health and Physical Education National Curriculum Statement (1995):

This essential learning area encompasses integrated learning processes which inform, extend and critique practices that promote the health, development and wellbeing (sic) of individuals and groups who live a changing world (p.1).

The policy specifications gave the green light for this curriculum to not only provide students with information that might promote their health and well-being, but to challenge them to critique and extend health practices. Tasker gives the example of the Victorian (Australia) Ministry of Education’s Personal Development Frameworks that encourages students to evaluate social conditions in relation to health problems, and to develop a ‘socially critical perspective about health issues’. As well, the Victorian approach suggested that where practicable, students should extend their learning beyond critique and become involved in ‘action projects’ for health. Tasker draws on the post-

modern writer, Freire (1973) and his concept of empowerment, giving the 'well known example' of social action by children and students around issues of community and societal concern. The policy specifications had also supported this direction:

The aims of the Health and Physical Education curriculum are to enable students to participate in creating healthy communities and environments by taking responsible and critical action (Ministry of Education, 1995:2).

Tasker (1996/97) takes the element of 'critical action' further, picking up on the notion of participation in the creation of healthy communities and environments and suggesting that health education should be emancipatory. This post-modern approach to health education is part of a wider reformative and transformative pedagogy (Kemmis and McTaggart, 1988) with an agenda of social and institutional change. Through encouraging students to question and analyse existing social and historical formations such as classrooms, school and society, teachers would be engaging in a 'process of social and historical reformation or transformation - a struggle for reform', in the interests of health and well-being:

A curriculum based on this model aims to enable learners to participate in a broad range of learning experiences that can empower them to develop the knowledge, skills and attitudes needed to enhance personal identity and health status. It encourages them to critically interpret their own and other's health experiences; to think about these in real terms that analyse the social structures they are enmeshed in; and, to consider the contradictions and tensions underlying all health issues in our society. It involves the promotion of critical analysis and reflective thinking which would ultimately lead to the development of more informed decision making processes (1996/97:193).

This raising of critical consciousness about the impact of societal influences on individual health would challenge students to understand such things as structural inequalities and how these impact on health status. As Tasker (1996/97) argues, the curriculum has been designed to facilitate a 'personally liberating' pedagogical process, informing and encouraging a 'health-literate' society where the "critical analysis of

public policies and practices is encouraged, and where the learning outcomes generated by health education contribute to the nurturing of autonomous individuals and an empowered populace” (p.199).

The discussion in the previous chapter regarding the positioning of students as agents of change is equally pertinent here. Teachers are positioned as ‘critical consciousness raisers’ within this pedagogy of liberation. Students are assumed to be in need of liberation, begging the question ‘from what?’ Liberated from the authority of the teacher, the principal or the school? Liberated from the tyranny of health ignorance? Or liberated from the ‘public policies and practices’ that dis-empower and restrict personal autonomy?

Critical consciousness, once raised, can lead to disappointment, cynicism, and despair, if the resistance to action resulting from such consciousness proves too powerful. Teachers are treading a razor-edged ethical line if they position themselves as facilitators of critical consciousness raising. Again, following the discussion in Chapter Three, teachers, I argue, need professional development and systemic support before embarking on such a pedagogical journey.

The discourses enunciated by Culpin and Tasker in the two articles analysed above, indicate a resistance to neo-liberal discourses through firstly denigrating individualistic models of health, and secondly by promoting socio-ecological discourses and models. This was met with resistance from Ministers who were wedded to a neo-liberal, conservative ideology. The result was a curriculum that favoured personal health development with the lion’s share of the KALs, Strands, AOs devoted to advancing personal health, but with the Underlying Concepts enunciating liberal-humanist, empowering, inter-dependent and socio-ecological philosophies. Teacher development in support of the curriculum focusses on implementation and ‘curriculum delivery’. Evidence of this focus is the Ministry of Education’s publication of several ‘Curriculum in Action’ resource booklets which are based around the content of the curriculum. Teacher development in the philosophy and pedagogy of reform and transformation along with its discourse of emancipation has not occurred.

Alongside Culpin and Tasker's discourses, other writers were using health education and health promotion discourses that sound familiar in the light of the curriculum.

## **Chapter Four**

### **A recent archive**

Against a background of political and educational ‘reform’ in New Zealand, this chapter explores an archive of health promotion and health education discourses which were available for use by the curriculum developers and writers during the period of curriculum development. Because of their professional experience, interest and expertise in the health promotion and health education area, the curriculum developers and writers would have been familiar with current and recent health education and health promotion literature, text books and academic journals. During the curriculum development time the Ministry of Health was providing regular policy advice, putting health sector public health and health promotion discourses before the Ministry of Education and the writers. In the context of this thesis, I am interested in analysing those available discourses that relate to the subsequent health education and health promotion discourses of the curriculum (Chapter Three). I am interested in the rules that define the use of the discourses, how the discourses position students and teachers, and what discursive devices are used to buttress and support the discourses.

#### **Health education and health promotion discourses in the professional literature**

Most discussions and analyses of health education and health promotion begin with or include definitions of health, although some have concluded that the whole effort to define health is unhelpful and ‘de-energising’ (Ashton & Seymour, 1990). A health promoter who defines health in line with, say, the World Health Organisation’s ‘absence of illness and disease’ will choose models of practice more preventative and individualistic in focus than a health promoter who defines health as ‘well-being’. While this may be the case, I resist the urge to enter into this discussion, and place my trust in the archive to show how the word is used in the context of professional discourse. My aim in this section is to explore health education and health promotion

discourse as used by practitioners, not to define health, but to understand the discursive rules that govern the use of the discourses of health, health education and health promotion.

To organise the recent discourses under analysis, I group them loosely into ‘themes’ each of which suggests a discursive rule for the use of health education/promotion discourses at this time. Several themes and ideas are evident when analysing recent health education and health promotion discourses. There is a theme of ‘discursive domination’ (where the discursive rule indicates health promotion discourse is dominant over health education discourse); a theme of ‘interdisciplinary influence and complexity’ (where the discursive rule positions health promotion as a composite discipline); a theme of ‘public health and environments’ (governed by a socio-ecological discursive rule); and a theme of ‘support, enablement and empowerment’ (with a liberal-humanist rule of discourse use). These themes and rules are, I argue, evident in the sub-archive of health readily available in health education and health promotion texts.

### ***A discourse of ‘discursive domination’***

I indicated in the Outline to this thesis that the recent discourse in the field of health education and health promotion can be seen as confused and blurred. This is clearly illustrated by looking at the use of key concepts and terminology by authoritative writers in health education and health promotion. In one of the most recent definitive publications in the field, Glanz et al. (1997) give weight to the observation that health education and health promotion discourse is unclear. Early in Part One of *Health Behavior and Health Education: Theory, Research, and Practice* Glanz discusses, as would be expected by the title, the foundations of health behaviour and health education. Then, with no obvious reason or explanation she informs the reader that the first chapter of her book covers “the scope of health promotion and health education” (p.3, my italics). Whilst the sub-headings of her first chapter are consistent with the title of the book and indicate a focus on health behaviour and health education, there is also a

strong focus on health promotion.<sup>19</sup> This is similar to the situation touched on in the Outline of this thesis, where the Health and Physical Education in the New Zealand Curriculum (Ministry of Education, 1999) uses health education in its title then proceeds to disregard that term throughout its pages, using instead the term health promotion.

Glanz's text uses the discourse of health education and health promotion according to the rules of the time. It goes without saying in 1997, that a book on health education must also be about health promotion. The two terms are used closely together, and with ease in each other's company. In a similar way Reid's (1997) health promotion discourse includes the health education discourse within its aegis. For her, the health education discourse of informed decision-making, and individual behaviour change are part of health promotion.

There are some interesting rules in the use, placement, and ordering of key terms in book titles, indicating focus, emphasis and dominance. For instance, whilst the title of Glantz' (1997) book indicates a focus on health behaviour and health education, the term health promotion is introduced in the first sentence of the opening chapter - "The range of health promotion and education activities today is nearly limitless"(p.3) and is ordered ahead of health education. In addition, whenever the term health promotion is used, it appears fully, unlike health education which sometimes loses part of it's name (health) - either by being paired with, and following health promotion (ie health promotion and education) or by perhaps being subsumed within the broader term 'education' (ie health behaviour and education foundations). These examples serve to support the view that for Glantz, health promotion is the favoured term, and conversely, health education less favoured. Yet curiously the term health promotion does not appear in the title of the book. One possible explanation is indicated by Hall & Gieben's (1992) idea that recent discourses contain vestigial traces of past discourses. Glantz is using an earlier, more familiar health education discourse in constructing the title of the

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<sup>19</sup> The subheadings are: Health, Disease, and Health Behavior; Health Promotion, Health Education, and Health Behavior; Settings and Audiences for Health Promotion and Education; Progress in Health Promotion and Health Behavior Research; and Health Behavior and Education Foundations and the Importance of Theory, Research, and Practice" (Glanz et.al.,1997,4-14).

book. Perhaps she is attempting to market the book to an audience which is more comfortable with (an earlier) health education discourse, but which is in the process of making the move towards (a newer) health promotion discourse. Whatever her reason, it seems clear that the trace of a health education discourse remains embedded within her health promotion discourse. Lupton's (1997) term 'discursive domination, which I introduced in Chapter One, usefully explains how health promotion has 'captured' the discourse of health education and 'secured it within its bounds' (McHoul & Grace, 1993).

Tones believes that health education is not synonymous with health promotion. Instead he, like Glanz (1997) and Reid (1997) sees health education as a 'major component' of health promotion, adding that "without health education the purposes of health promotion are unattainable" (p.13).

This example of a blurring between health education and health promotion is understandable given McHoul & Grace's (1993) observation that discursive forms, whilst quite distinct from one another, may or may not share the same names. They are discontinuous, but can "also overlap and intersect as they change historically" (p.31).

There is much space given to the discussion of health education in relation to health promotion within the archive. Glantz (1997) discusses the current favoured use of health promotion over health education, suggesting that health promotion has developed in response to limitations in the scope and practice of health education during a recent twenty year period:

In the field of health education during the 1970s and 1980s, the emphasis on individual's behaviors (sic) as determinants of their health status eclipsed attention to the broader social determinants of health. Advocates of system-level changes to improve health then called for renewal of a broad vision of health promotion (Minkler, 1989; Terris, 1992). These calls for moving health education toward social action are well within the tradition of health education

and are consistent with its increased concern with social, economic, and political forces”(p.6).

Glantz is suggesting that the 1970s and 1980s was a crucial period in health education discourse, loosening its traditional discursive links with social determinants of health, and strengthening its discourse of behaviour change with a focus on the individual. This leads her to define health education and health promotion separately. It is interesting to note that her definitions of health education all spring from the 1970s and 1980s whereas the definitions of health promotion are drawn from the later mid 1980s and 1990s. She comments that health promotion is a more recent term than health education, supporting the theory that there has been a discursive shift in recent times. Such discursive shifts occur, according to Foucault, when the contingencies surrounding discursive use change, when there are changes in practice, conditions, context and the power relations that allow certain things to be said, and other things to remain unsaid. In the following chapters, I will attempt to discuss some of these contingencies.

Glantz (1997) and Green & Kreuter (1991) both place the discourse of health education as one aspect of (or support for) health promotion. Glantz’ (1997) definition of health education emphasises learning experiences, health behaviour change, informed decision-making, closing the gap between health knowledge and practice, and the importance of health action. Her health promotion discourse includes aspects of this health education discourse but adds a range of other discursive resources such as the creation of environments (i.e.organisational and economic) that support health; the enabling of people to increase control over their own health; and the reduction of inequities.

Glantz (1997) states that the “central concern of health promotion and health education is health behavior (sic)” (p.9). Certainly, Glantz’ health promotion discourses do not omit this aspect. It is clearly part of both discourses. There are however differences in the way behaviour change is talked about. Health promotion discourse includes behaviour change but uses the term ‘lifestyle’ change as well. Health education talks of

informed decision making and learning experiences - discourses entirely absent from health promotion discourse. However, health promotion does include health education as one of the 'supports' for health-conducive behaviour. Glantz observes that health promotion "emphasizes (sic) efforts to influence the broader social context of health behavior (sic)" (p.9). Certainly Glantz' cited discourses of Green and Kreuter (1991), O'Donnell (1989) and Epp (1986) bear this out.

In line with the title of their book *Health Promotion: Theory and Practice*, Kemm & Close (1995) are clearly focussed on emphasising health promotion, devoting all nineteen chapters (except four which cover aspects of health education) to health promotion ideas and issues. They take a broad view of health promotion and see education (not health education) as with one key health promotion activity. Like Tones (1996), Kemm & Close see education as a process operating in two important ways: firstly by producing changes in knowledge, attitudes and skills; and secondly in it's role of motivating people to adopt health-promoting behaviours. In a chapter which looks at the school as a setting where one might expect the focus to be on (health) education, the main emphasis is instead on the 'health promoting school'.

By the late 1990s then, health promotion discourse is broader than health education. It includes health education discourse, but involves much more. Kemm and Close(1995) define it as "all those activities which are intended to prevent disease and ill health and to increase well-being in the community" (p3) - a broad, all-encompassing definition which indicates the huge scope of health promotion.

The discursive moves above indicate a shift in emphasis from a health education to a health promotion discourse in recent times, with health promotion being used as the more inclusive term. This move, I argue, effectively captures health education discourse within the bounds of health promotion discourse, placing health promotion in a position of dominance in relation to health education.

The *Health and Physical Education in the New Zealand Curriculum* (Ministry of Education, 1999) clearly uses this discourse according to its rules. It is certainly blurred

and confused in its positioning of the two key terms, health education and health promotion. The lack of any discussion about the relationship between health education and health promotion serves to cement the confusion. Its title gives dominance to health education, but, as has been stated, does not use the term within its text. Instead, health promotion dominates in the document: it is defined, and given a dominant position in the Underlying Contexts, along with the related and supportive discourses of hauora, well-being and a socio-ecological perspective. The writers indicate a strong antipathy towards concepts traditionally associated with health education (eg. 'healthism' and individual behaviour change), and argue for a broadly health promotion approach, thus marginalising health education in favour of health promotion.

### ***A discourse of 'interdisciplinary influence and complexity'***

Discernable in recent health promotion writing, is a recognition that health promotion is a multidisciplinary field, or as O'Connor & Parker (1995) view it, as a 'multidisciplinary approach'. Nutbeam & Harris,(1998), and Bunton & Macdonald, (1992), discuss the breadth of health promotion and the way that it draws upon a range of disciplines in addition to education and psychology, disciplines such as sociology, management, consumer behaviour, marketing and policy studies. For Nutbeam and Harris health promotion practice is "not only concerned with the behaviour of individuals but also with the ways in which society is organised and the role of policy and organisational structures in promoting health" (p.10). This means that in order for practitioners to work effectively towards social and organisational change, there will be a need to develop new professional skill bases beyond, say, education or psychology. These new skill bases will be drawn from such disciplines as management, marketing, community development and policy studies.

Reid (1997) talks about an emerging postmodern paradigm of social change where "new ideas and practices grow out of practical experience...and competing ideas can productively co-exist" (p.1). Difference is respected. Health promotion is 'complex, diverse and dynamic'. It is about:

bringing about social change, about changing community norms, values and individual behaviour. It is about the synergistic interaction between individual and larger system change, be that larger system an organisation, a community, an economy, a political system or the intersection of a number of these or other systems (ibid.).

To bring about change at these levels requires understandings and skills drawn from a wide range of disciplines. Increasingly health promoters, exposed to this discourse, are recognising the interdisciplinary influences on their practice, and the complexity of the work they are expected to do.

A wide range of health education and health promotion theories and models have emerged from, and draw upon, a range of discipline bases. The theories and models have been comprehensively mapped and described by several writers (Ross & Mico, 1980; Ewles and Simmet, 1985; O'Connor & Parker, 1995; Pike, S. & Forster, D., 1995; Kemm & Close, 1995; Glanz, Lewis & Rimer, 1997; and Nutbeam & Harris, 1998). However, health promotion thrives in a mostly oral tradition with major developments in practice told narratively at conferences rather than being documented in theoretical literature. Moreover, most health promotion models have been unaccompanied by much detailed theory work or explicit ideology. They are a manifestation of an emerging profession's struggle to develop core theoretical underpinnings from the practice base:

Research in health promotion and education has an inherently applied cast; it is motivated and driven by service to existing or anticipated health concerns, (Glanz et.al.1997:20).

This practice-theory gap in the day-to-day work of health promoters means that models such as those used by health promoters must be believable and attractive to those who eschew intellectual work and who see themselves as practitioners, not theorists.

Given these observations and comments, health promoters readily draw upon a range of models drawn from other disciplines to either describe or guide their practice. These

models and theories can be grouped as follows: educational theories; theories that explain change processes in individuals; theories that explain change in communities, and organisations; and theories of policy development. What is apparent with all the theories and models, is the way in which health education and health promotion have borrowed from theories developed in related disciplines to find ideas for promoting change - change in individuals, change in groups, and change in human social structures and processes. Health educators and health promoters are, to a greater or lesser extent, change agents and the theories and models that drive their practice clearly reflect this aspect of their work.

The discourse of recent (mid 1980s to the present) health education and health promotion theory does not draw heavily on education and psychology. For that reason, the bulk of these discourses will be discussed in the analysis of the earlier archive (Chapter Five). However, one broadly educational theory, was being used by health educators and health promoters in the mid to late 1980s.

### *Educational theory*

Following the work of its most influential writer, Bandura (1986, 1995), social learning theory has developed as a complex theory widely used by health promoters because of its proven effectiveness over time. Its strength lies in its comprehensiveness. It includes key ideas of the health belief model (the importance of knowledge and beliefs and their influence on behaviour) and of the theory of reasoned action (social norms and their influence on individual behaviour) (see Chapter Five) and builds a theory which accounts for environmental influences on health behaviour, providing practical direction on how to modify each of these influences. In the education sector, Bandura's writing on self-efficacy (belief in yourself) and self-confidence has been powerfully influential in the importance teachers place on self-esteem in health education programmes. As well, teachers have been influenced by Bandura's emphasis on the power of observational learning, using this to ensure that positive role models are part of their health education programmes. However, this discourse fails to provide discursive resources for teachers on the importance of environment or situation on subsequent health behaviour. Consequently, health education teachers are likely to become

frustrated that health behaviour learned in the classroom often fails to transfer into real-life situations outside of the classroom setting.

Most recent health promotion discourse focuses upon attempts to explain how change occurs in communities and how communal action can be undertaken for health. Recent theorists talk about factors that affect health, looking to find those factors not so much within individuals and individual behaviour, but in the communities and social environments in which people live (social determinants). These discourses are enunciated and discussed below.

### *Community change*

Discourses of community mobilisation have been utilised by contemporary health promoters to better understand the health behaviour of large groups and communities, and to guide community-wide interventions. These discourses position the health promoter as a change agent, powerful in the ability to intervene in, and activate communities towards certain health outcomes. The community in contrast is positioned as rather immobile, apathetic or ineffective without the intervention of the health promoter; it needs the health promoter in order to act in the interest of its own health; it needs 'mobilising' into positive health action - action which would not have happened without the input of the health promoter (or some other motivator). Conversely, the health promoter is positioned as energiser, motivator, and effective change agent. There is a sense in which the health promoter 'wakes' people up from sleep, and prods them into action for their own good. Such 'empowering' action can be seen as a small step away from agitating and stirring up unrest in a community. A health promoter would need to be very careful to ensure her mobilisation was indeed wanted by the community, and matched its aspirations, not destabilising a community, needlessly creating change or raising unattainable expectations.

There are several key aspects to the discourse of effective community mobilisation. There is the job of building community and the capacity of a community to act for health. Labonte (1993,1994,1997), drawing on the earlier work of Friere (1973), puts forward impassioned arguments for the moral imperative of empowering communities

through active participation in decision making and the forging of meaningful partnerships for health. Underlying his work is a strong adherence to the discourse of community and the important interactions that occur between community and individuals. This ecological approach has proven its effectiveness across a wide range of social settings, and health issues (Avery, 1990; Harvey, Tuffin & Tuffin, 1990; Labonte, 1993; and Minkler, 1992), increasing the use of its discourse within the repertoire of health promoters. Labonte (1993) argues that when people understand the political and social structures and practices that lie beneath their health problems, they will be better able to change their situations through developing action plans based on critical reflection. As we saw in Chapter Three, this 'social ecological' and 'critical action' discourse is discernable as a key discourse within Health and Physical Education in the New Zealand Curriculum (1999) especially in the development of its conceptual framework and in the discussions of its principal writers. The discourse of community mobilisation emphasises the central position of "the community in problem definition, planning and action to solve problems [as well as] the establishment of structures to ensure that solutions are sustained" (Nutbeam & Harris, 1998:37).

The achievement of health change in communities is a complex and multi-layered process. Nutbeam and Harris (1998) argue that such community change increasingly involves health promoters in the social, economic and environmental determinants of health, helping people to develop personal skills for health as well as helping communities to build their capacity to act collectively. Many choose to take an ethical stance towards the reduction of inequality within communities and become involved in building the capacity of the least advantaged. Health promotion becomes a political and moral activity; the language of health promotion becomes overtly political; the neutral professional is anathema to the work of such health change agents.

This socio-ecological discourse which pervades recent health education and health promotion theory not only positions health educators and health promoters as agents of individual behaviour change, it especially positions the health promoter as an agent of social and environmental change. In Chapter One I discussed Foucault's idea of how a discipline (and the professionals working within such a discipline) can be made

vulnerable to being used as instruments of governmentality. The power of the discipline of health education and health promotion, its knowledge and techniques (especially those of individual and social change), can be appropriated by governments to bring about changes in support of that government's ideology. Certainly governments have an interest in shaping and changing people towards certain ends. If there are ways of using existing, legitimate structures (in this case a profession or discipline such as health education or health promotion) to achieve those ends effectively and economically, it makes sense that they would do so.

Another key discourse enunciated by many contemporary health promoters draws upon communication theory and mass communication discourses in relation to shifting a community's health action. The communication-behaviour change model (Atkin and Wallack, 1990; Egger, et.al., 1993; McGuire, 1989), and social marketing theory (Andreasen, 1995; Kotler and Roberto, 1989; Ling et.al., 1992) are examples of theories and discourses that have been used by health promoters to support this aspect of their practice. Both discourses provide a language for health promoters as they attempt to communicate health promoting messages to the public in order to bring about desired health change.

McGuire (1989) developed the communication-behaviour change model to assist the design and direction of public education campaigns. The model brings the knowledge and discourse of effective communication to the health promoter and focuses on several aspects of communicating health messages. The model encourages health promoters to take the utmost care in the design and delivery of health communications, and to make the effort to understand the values, preferences and 'mindset' of the intended audience. It is of interest to note how people are positioned using this model, as sources, channels, mediums or receivers. One is reminded of radio and television sets rather than living, breathing, emotional human beings. The human being that is constructed by such a mechanistic discourse is reduced to robotic proportions, able only to state values and preferences, thus making her even more 'known' and open to the manipulation of the (powerful) health educator or promoter. In comparison with (older) educational discourses (Chapter Five), the discourse of the communication-behaviour change model

can be seen to limit the capacity of the human being in making autonomous, informed decisions.

Another theory that has provided communication discourses for health promoters is social marketing theory. The theory has strong links to commercial marketing theory. Both theories refer to 'buyers' and 'sellers' and both share the intention of influencing how people think and behave. However, social marketing differs from commercial marketing theory in who it intends to benefit: people and society, rather than the marketer. However its principles are similar to commercial marketing theory, and health promoters use them widely when attempting to influence consumer choice.

The discourse of health communication and marketing, in line with neo-liberal discourse, positions people as health consumers who are exposed to a range of health 'products' (ideas, programmes or technologies). Social marketing uses marketing discourse and principles to guide health promoters through the processes of market analysis, the appropriate selection of channel, message delivery and source in a similar manner to that suggested by the communication-behaviour change model (above). It is helpful in achieving the best 'marketing mix', and in monitoring the impact and effectiveness of the chosen marketing strategy. Social marketing:

encourages creative approaches to the analysis of issues and development of programs...[It] has supported experimentation with the use of a wide repertoire of different intervention methods including mass communication, sponsorship of events, and competitions, all of which have been effectively used for health promotion" (Nutbeam & Harris, 1998:53).

Social marketing techniques rather than, say, Frierean approaches, can pose certain moral tensions and ethical dilemmas for some health promoters. This is especially so when those techniques position the health promoter as a 'hard sell' marketer, dealing with commercial sponsors or using competitive rather than cooperative strategies (Tuffin, 2000). For those who do choose to use the techniques offered by social marketing, it arguably provides a research-based planning model with strength in

evaluation and feedback. In addition its integration of elements of other theories (such as the earlier health belief model and the communication-behaviour change model) allows health promoters to implement effective mass communication campaigns. The social marketing discourse positions human beings as clients, consumers and buyers in a health market. The consumer can choose between the message and product of the health promoter, or that of say, the tobacco or fashion industries. At times it may be difficult for the consumer to tease a health message out from a (sometimes anti-health) commercial sales message, especially when commercial sponsorship is involved in marketing the health message. For example, consumers could well have difficulty recognising, let alone teasing out, the health message in the placement of McDonalds as the in-house caterer at Starship Children's Hospital in Auckland.

The pervasive neo-liberal discourses of freedom, individual choice, markets, consumers, profit and progress has been readily used by many health promotion professionals, especially those who have chosen to use health promotion models that utilise the same discourse, such as social marketing theory. In much the same way, theories of organisational change, which grew from neo-liberal philosophy and discourse, were appropriated by many health promoters during the late 1980s and early 1990s to assist in the work of influencing and changing a wide range of organisations towards the promotion of health.

### *Organisational change*

Reid (1997) recognises the influence organisations have on health. This influence can be direct (ie. health and safety in the workplace) or less direct (ie, an organisation's ability to influence the policy of another organisation). With this recognition of the ability of organisations to influence health, many health promoters have begun working with organisations, attempting to change their culture, policies and practices for health. To do so, they draw upon theories and discourses of organisational change (Goodman et.al.,1997) and the theory and discourse of intersectoral action (Goodman et.al.,1997; O'Neill et.al.,1997; Harris, et.al.,1995; Butterfoss, et.al., 1993. Certainly, health promoters working within the school setting, readily draw upon such theories in their attempts to change school culture, policies and practices for health.

As health promoters do this, they can be heard using the discourse of management theory and practice to explain organisational change conducive to health, finding useful analytic and planning tools to help promote health change in organisations. Goodman, Steckler and Kegler (1997) offer a four-stage model for organisational change which has been useful for health promotion practice, stage 1 being awareness raising, most effective at the senior management level where clarification of the health problem aims at gaining management commitment to move to stage 2. Stage 2 is adoption, where planning, resource considerations and consultation with stakeholders occurs, followed by Stage 3 implementation. During this stage there may be a need to provide training and support to ensure capacity-building occurs. Finally Stage 4, institutionalisation is reached when the desired change has become part of the culture, policies and practices of the organisation, with ongoing evaluation, support and investment to ensure the maintenance of the innovation into the future. This discourse positions the health promoter as 'manager' of change. As such, she works primarily with senior management within the organisation, ensuring management plans and implements the desired change in the context of that organisation. The human subject is positioned as a stakeholder in this change, having input into the process of planning for change. However, a stakeholder in this scenario can also be seen as being part of planned interventions which may occur without their knowledge, input or agreement. They may be so far down in the hierarchy of the organisation, that the 'innovation' is effectively foisted upon them by senior management in what could be seen as paternalistic or imposed.

### *Policy development*

As has been indicated in many of the theories and models discussed above, health promoters often become involved in policy development and change, within organisations and within the public arena. Milio (1987) suggests health promoters use an ecological discourse when working to develop or change policy, while DeLeeuw (1993) has developed a model which outlines the determinants of policy-making. Each of these writers contributes useful guidance and discursive tools for health promoters as they position themselves as policy developers for health.

Milio's (1987) rather postmodern work emphasises the dynamic nature of policy development in comparison with more positivist linear models which tend to focus simply on the production of a written policy or policy statement. She brings an understanding of the ecology of organisations to health promotion practice as well as an understanding of how organisations work. Her ecological discourse includes recognition of the different roles and influence of the stakeholders, the social climate or context in which the policy is being proposed, the varying interests at play in policy development, and the capacity of stakeholders to develop strategies that will ensure their interests are met.

An understanding of factors that determine policy making is essential when embarking on any development of healthy public policy. Like Milio (1987), DeLeeuw (1993) cautions the policy-maker to become fully aware of a wider picture, in this case the intentions, values, interests and power positions of all stakeholders. There is recognition of multiple world views and realities, and the idea that there are power positions at play within policy making.

Each of the theories and discourses outlined above bring understanding, guidance and insight into the increasingly complex discursive field of the contemporary health promoter. Commentators such as Nutbeam and Harris (1998) and Glanz et.al (1997) stress the need for health promoters to draw upon as many theories and discourses as possible when planning projects or interventions. Promotion of health is multi-layered, with interactions and relationships occurring between individuals, their beliefs and interests, communities and organisations and their various cultures, capacities and processes, environments and settings. All of these layers determine health outcomes, and all need to be considered in effective health promotion practice. The discourse of public health, environments and settings for health is evident in the contemporary and recent discursive repertoire of health promoters.

### ***A discourse of 'public health and environments'***

O'Connor & Parker (1995) use a health promotion discourse that places it within an even broader discourse, that of public health. Health promotion includes both

individual behaviour and social conditions as determinants of health, but does not rely on one discipline (ie education) to achieve the public health goal of improving 'the nation's health'. Their health promotion discourse is more firmly 'at home' with public health discourse, than with education discourse, highlighting two reasons that make health promotion a vital approach in public health - the impact of human behaviour on health, and the impact of social milieu on health - suggesting that health promotion is able to work both in the area of human behaviour as well as on the social determinants of health. Because of their view that health promotion is a 'multidisciplinary approach' they are interested in how this approach can be used to tackle "current causes of mortality and morbidity and to advanc[e] the public's health"(p.xv). They see health promotion not so much as an educational process but rather "a political, social and economic process and...a set of strategies for improving the nation's health" (p.8).

Public health discourse has, since its inception, used a discourse of environments. Early (late nineteenth and early twentieth century) public health movements grew out of environmental conditions that were believed to encourage and spread infectious disease. Recent health promotion discourse such as Reid's (1997), emphasises the inclusion of environments as a crucial factor in health with an emphasis on the creation of environments conducive to health. The inclusion of such an 'environment' discourse is evident in the writing of Green & Kreuter (1991) who see an element of health promotion as the provision of 'economic, and environmental supports for behaviour of individuals, groups, or communities conducive to health'. In a similar way O'Donnell (1989) and Epp (1986) include the creation of environments that support good health practices in their definitions of health promotion. These discourses share a mandate to support both behaviour and environments for health.

Unlike these strongly socio-ecological discourses of the later 1990s the slightly older discourse of the late 1980s emphasises a language of support, help, facilitation, and enablement, along with a commitment to improving people's lives and reducing inequality.

### ***A discourse of 'support, enablement and empowerment'***

This discourse is discernable with more recent discourses of health education and health promotion. For instance, Reid (1997) emphasises 'empowerment and responsibility rather than a predefined good'. People have the capacity and will to act, if given access to the information they need to make informed decisions, and to the resources which empower action. As well, Tones (1996) focuses on the ideology of health promotion, and on its key empowerment role, noting that the concept of health promotion developed out of World Health Organisation (WHO) initiatives beginning in 1977. Discussing health education in Scriven and Orme's text *Health Promotion: Professional Perspectives* he hints of the shift that was occurring from health education to health promotion by noting that the relationship between education and healthy public policy is 'potentially synergistic':

As we well know, the provision of knowledge is a necessary though insufficient prerequisite for achieving educational goals. It must be supplemented by the all-important process of critical consciousness raising which seeks not only to generate a state of heightened and critical awareness, but also to create indignation and concern over social issues and injustices. Those familiar with the philosophy of Freire (1972) will more fully appreciate the purpose of critical consciousness raising and its associated methodology. In one form or other it should be central to the overall health education enterprise (Tones, 1996:16).

Tones, believes that the key components of health education and health promotion work at two levels. Firstly, at the individual level health education can empower and facilitate decision making and cooperation rather than having to use coercion, persuasion or compliance. Secondly, at the community level it can "achieve critical consciousness raising, empowerment, and subsequently, political action leading to the implementation of healthy public policy at national, local and organisational levels" (p.13). In a similar way Epp (1986) uses an 'empowerment' discourse by talking of 'enabling people to increase control over, and to improve, their health' and by encouraging a commitment to

dealing with the challenges of 'reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances'. Epp's discourse emphasises the creation of environments conducive to health, in which people are empowered to be able to take care of themselves.

Another enunciation of this supportive, enabling discourse is evident within a discourse of intersectoral collaboration and cooperation. The argument put forward by this discourse is that health is enhanced when different organisations and sectors work together in partnership to create health-supportive environments. Butterfoss, et.al., 1993; Goodman et.al.,1997; Harris, et.al.,1995; Labonte, 1997; Kean et.al., 1999; O'Neill et.al.,1997 suggest that intersectoral action and partnerships work effectively when there is a will to understand context and the different 'cultures' of each organisation and to work towards shared or common goals. On one hand this discourse enunciates humanist supportive relationships and cooperation, while on the other hand it utilises the market discourse of partnerships and goal setting. The health promoter is positioned as a complex professional, able to move easily and confidently between diverse organisational cultures, and between quite disparate ideologies enabling, supporting and empowering those organisations to work towards common health goals.

Many of the above discourses are discernable in the principles of the earlier Ottawa Charter (WHO, 1986), the landmark public health statement on health promotion.

### **The Ottawa Charter for Health Promotion**

The charter defines health promotion as:

the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. It has come to represent a unifying concept for those who recognise the basic need for change in both the ways and conditions of living in order to promote health. Health promotion represents a mediating strategy between people and their

environments, combining personal choice with social responsibility for health to create a healthier future.

Within this definition, there is no blurring or confusion between health education and promotion. Health promotion stands firmly on its own ground, that of enabling people to gain greater control over the factors that affect their health - their lifestyles ('ways of living') and their environments ('conditions of living'). Health education is assumed within the broader term, health promotion. The health promoter is positioned as a professional who works to empower people through using what could be interpreted as health education strategies ('personal choice') and through community action ('social responsibility').

### ***Development of the charter***

This mid-1980s definition of health promotion emanated from conditions within WHO's European region, where, by 1984 a militant wing of HFA2000 had emerged and published a discussion paper outlining the concept of health promotion and its principles (World Health Organisation, 1984). In a comment on this publication, Kickbush (1986) described health promotion as 'a new force-field for health, integrating social action, health advocacy and public policy'. The 1984 discussion paper was followed by the WHO conference held in Ottawa, where delegates from thirty-eight nations committed themselves to health promotion principles and enshrined them in the Ottawa Charter for Health Promotion (WHO, 1986).

### ***The Charter's Principles***

The charter identified five principles of health promotion practice. Health education appears as part of only one of these principles - 'develop personal skills'<sup>20</sup>:

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their

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<sup>20</sup> The other four principles of the Ottawa Charter for Health Promotion (WHO, 1986) are: strengthen community action; reorient health services; create supportive environments; and build healthy public policies .

own health and over their environments, and to make choices conducive to health. Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

The other four principles of the charter put health on the agenda of policy makers, state a clear socio-ecological approach, urge community development and action, and challenge everyone to develop health care systems that contribute to the pursuit of health (not illness).

Subsequent WHO health promotion conferences in Adelaide (1988), Sundsvall (1991) and Jakarta (1997) maintained the primacy of health promotion discourses and strategies at the expense of health education. Delegates at each of these conferences were representative of a range of disciplines within health - public health, community health, and medicine - ensuring that this enunciation of the charters health promotion discourse was taken back to be heard by most professional groups working within the health sector. New Zealand health professionals were present at each of these conferences, and similarly brought back the language of health promotion, subsequently using it in their professional discourse, and embracing it within their practice and policies.

The power of using Foucault's method of working backwards in time, is the way in which recent discourses in health promotion and health education can be seen in this mid-80s definition. The charter's discourse is clearly evident in the discourses of the 1990s. It sets discursive rules that de-emphasise individual behaviour change in favour of social and environmental change. Whilst health education ideas are evident within this definition, especially that aspect of personal choice for health, it is not clearly identified nor is it labelled. The charter's definition of health promotion rests instead upon an understanding of the determinants of health. Simply, health determinants are those factors ('conditions of living') that affect or shape our health and well-being - such as income and education levels, housing, political stability, work load, exposure to

environmental pollutants, etc. Health promotion is then seen as all those strategies (the 'process') used to ensure people can do something positive about ('increase control over') these factors. The charter enunciates another key aspect of health promotion - the relationship between people and their environments, and the relationship between individuals and society. Health promotion becomes a 'mediating strategy', ensuring linkages are made in a broadly holistic manner.

The Ottawa Charter's ideology and discourse focusses upon the building of healthy public policy, the empowerment of individuals and communities, strengthening community action, re-orienting health services towards prevention and promotion, and the creation of supportive environments for health. The charter acknowledges the importance of social, political, and economic processes in the achievement of health gains. It's language was swiftly accepted as a legitimate discourse by health professionals, especially those working in health education within public health. Within a very short space of time, I argue, it became increasingly dominant, with a subsequent marginalisation of health education discourse, subsuming it within the broader discourse of health promotion.

As I have indicated above, the discourses enunciated by theorists, health educators and health promoters above, do not occur in a social or political vacuum. The 1990s have been a time where multiplicity and complexity have been part of the social and political milieu. In New Zealand in 1992, the 'first past the post' system for electing governments was discarded in favour of a relatively more complex proportional system; diversity was becoming more widely celebrated (or tolerated), with, for instance the passing of laws recognising homosexual relationships, the proposal of new laws to decriminalise prostitution, and with cities holding annual festivals in recognition of the diverse cultural, lifestyle and ethnic mix within their communities.

Within government, various policy initiatives affecting health education and health promotion have been championed. Two key governmental agencies involved in the development of such policies are the Ministries of Health and Education. In the process of policy development the ministries are, as a matter of course, involved in the

dissemination of health education and health promotion discourses making available health education and health promotion discourses to health educators, health promoters, and of interest in this thesis, to curriculum writers and teachers. Two key initiatives where the discourses of health education and health promotion are actively being used within the context of schools, are the Ministry of Education's development of the curriculum (Chapter Three), and the Ministry of Health's Health Promoting Schools.

### **Health Promoting Schools - intersectoral collaboration?**

Health Promoting Schools, a Ministry of Health initiative, is a key development within the context of health education and health promotion in New Zealand schools. The story of this initiative provides an insight into the pivotal relationship that exists between the health and education sectors and the way key discourses have been used, shared and contextualised as the initiative has developed.

#### ***Development of Health Promoting Schools***

The present state of Health Promoting Schools in New Zealand reflects the fact that its key funder and driver is the Ministry of Health. Apart from one region (the lower North Island), the initiative is contracted through the Ministry of Health directly to health providers. In the lower North Island, the contract rests with an education provider in an attempt to buy-in education sector involvement (Tuffin, 2001). The Health Promoting Schools initiative is conceptually complex, calling for partnerships between education and health, schools and communities, in the ambitious attempt to change schools' environments, organisation, policies and practices for health. The way in which the Ministry of Health funds and contracts the initiative, using the health sector workforce to develop the initiative, has created conditions which arguably complicate rather than ease or simplify the process for schools. As well, the relative silence of the Ministry of Education on the initiative undermines the importance of the partnership between the two sectors. Having said that, the Ministry of Education has given some policy direction to schools to take on the Health Promoting Schools concept (Velde,

2000)<sup>21</sup>, but has fallen short of providing funding to support the initiative. The workforce resource (teachers) is being neither strategically targeted nor supported by Education to implement Health Promoting Schools (Hobbs, 2002). For instance, Health and Physical Education advisers, funded by the Ministry of Education and working in schools to support the implementation of the curriculum have not been contracted to output any work they might do towards supporting school communities within a Health Promoting Schools framework. There is a tacit understanding that Education's contribution to the Health Promoting Schools initiative is its workforce, but this is an informal understanding, not formalised at the level of contracts or outputs.

Late in 1995 the Ministry of Health hosted a Beehive launch of Healthy Schools: Kura Waiora, a resource folder for schools aimed at encouraging them to begin developing healthy policies to 'complement the teaching of health education'. In a press release by the Minister of Health, schools were complimented for work they were already doing in 'promoting healthy activities and programmes within the school environment'. The Healthy Schools concept was described as being based on the WHO health promoting schools concept. "This concept has been adopted by many countries around the world and is based on health programmes and initiatives which support the work of schools and their communities to enhance the health of their students. This approach enables people from the health and education sectors to work together" (Ministry of Health, 1995). The resource was issued to every school in New Zealand, and was actively supported by public health nurses and other public health workers in their wider health promotion support role within schools.

In many parts of New Zealand public health nurses had been working for some time towards changing the perception schools have of their role within schools. They had been using a variety of strategies in their attempt to shift schools' perception of health promotion, by for instance withdrawing from curriculum delivery (health education) and focussing on supporting teachers through provision of professional development or

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<sup>21</sup> A broad school health promotion programme driven and funded by the Ministry of Health through the Health Funding Authority and mainly staffed by health sector workers ie. public health nurses.

through supplying health education resources. As well they were available for advising on clinical, structural, social, and environmental aspects of health within a school. Those schools who were serviced by such 'health promoting' public health nurses, would have been hearing health promotion discourses (through the nurse) since the late eighties. This would have occurred whenever, for instance, the public health nurse suggested the school develop health policies such as smoke-free, nutrition, or HIV/AIDS policies, or when she declined an invitation to take a lesson on, say, hygiene, informing the teacher that her role was no longer so much 'health educator' but 'health promoter' and that it would be more appropriate for her to work systemically with the staff at, say a staff or syndicate meeting.

Kura Waiora followed a WHO initiative on school health promotion. In 1994 WHO's Regional Office for the Western Pacific convened a workshop whose purpose was to identify current conditions in schools, current practice of health promotion in schools, and barriers to the development of health promoting schools. It made recommendations for the support of health promoting schools in the western Pacific region. In the report of the workshop (WHO, 1995) Nutbeam provided a health promotion discourse based on a number of fundamental principles: a holistic concept of health; equity of access to school education; empowerment through the development of knowledge and skills; and the inclusion of the whole school community in school activities. He stated that health promoting schools "encompass(es) the educational and social objectives of schools" (p.5). Actions schools could take to become health promoting were:

development of supportive health and educational policies, effective classroom teaching, provision of appropriate school health services, fostering family and community participation in school programmes, and attention to the school organization (sic) and ethos (ibid.).

The positioning of 'classroom teaching' within a wider list of health promotion activities supports the idea discussed earlier in the chapter, that the discourse of health education is becoming marginalised, with less discursive scope than that of health promotion.

At the workshop, the New Zealand situation was reported jointly by delegates from the Ministry of Education and the Ministry of Health. The key role schools have in the promotion of health of students was noted, as well as recognition that agencies other than schools also had important roles to play. New Zealand schools were required to provide health education and a safe and healthy physical and social school environment. A separate health curriculum was in place, which was well-integrated with the wider curriculum. It was reported that the Ottawa Charter<sup>22</sup> had been used as the basis of the New Zealand's healthy (health promoting) schools framework.

The wide brief of health promotion, with health education included as part of that brief, is evident in this discourse. No longer is school health the sole prerogative of teachers and public health nurses, but is the responsibility of everyone associated with a school, ie. parents, boards of trustees, community health agencies, policy makers, curriculum developers and teacher educators.

Earlier, in 1993 the New Zealand School Trustees' Association (STA), with support from the Public Health Commission (an offshoot of the Ministry of Health at that time), had called a conference in Wellington to discuss the possibility of developing a Healthy Schools initiative. At this conference, boards of trustees and staff were encouraged to focus on schools' goals, policies, programmes and curriculum to achieve healthier schools (Pears, 1994). Present was a mixture of health and education professionals and members of boards of trustees. For most delegates and teachers who came from the education sector, it was the first time they had been exposed to the discourses of health promotion (rather than health education). The initiative did not develop as envisaged, with observers noting a wide discursive gap between Health and Education. As several delegates at the conference commented, 'we speak different languages'. As a delegate at that conference, my observation would be that this comment reflected the 'lag' between education sector and health sector discourses.

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<sup>22</sup> See Chapter 4.

Of note is a discursive shift that seems to have occurred between the emergence of Health Promoting Schools and Healthy Schools. The term healthy schools implies a state of being. A school can be judged against certain criteria and deemed to be 'healthy'. Health promoting schools in contrast implies a process rather than a state echoing Reid's (1997) emphasis on 'process rather than projects'. This discursive shift recognises the dynamic nature of health promotion and is more sympathetic with the health promotion discourse of the later 1990s, with its emphasis on developing 'power-within' rather than the 'power-over' implicit in judgements made against set criteria.

This Ministry of Health initiative to support health promotion in schools had grown out of the Public Health Commission's 1993-1994 policy advice to the Minister of Health (Public Health Commission, 1994) in which it recommended a strategic direction to improve and protect the public health. This strategic direction was developed following public consultation, analysis of social and epidemiological evidence and with the advice of a World Health Organisation consultant (Pears, 1994). The commission embarked on strategic planning in public health believing such planning would offer 'considerable potential for ensuring health gain' (Pears, 1998). Public health goals were set, four of which related directly to children and young people. A key objective to ensure that those goals were to be achieved was to:

improve and protect the public health by developing strategies to maximise the positive effects of schools on health (1994:6)

The influential role of the Ministry of Health and the Public Health Commission in initiating health promotion discourses in the education sector was firmly in line with WHO initiatives and policy advice. The direction of this advice indicated a move from a focus on individual health behaviour change to a focus on populations, and the social, political and environmental determinants of health. As a consequence, the health sector was placed on a path to change the structures and institutions that impeded such policy to be enacted. This public health policy rested on the understanding that health education on its own was relatively ineffective in achieving the health outcomes it aimed to achieve and that it required the broader strategies of health promotion to

achieve Health for All by the Year 2000 (WHO, 1977). It was thought that health promotion strategies would be better able to achieve health goals than health education strategies alone.

In New Zealand, the education sector and schools were being targeted by the health sector to come up-to-date with current health promotion trends and discourses. What was required was a concerted effort by the health sector to shift schools from their focus on health education and an individualistic, behaviour change emphasis, to a health promotion or 'settings' focus. STA's Healthy Schools and public health nurses' initiatives were both part of this package of deliberate health sector influence upon the education sector. To support this policy direction, the Public Health Commission was funded to achieve its Healthy Schools targets. The Ministry of Health was prepared to foot the bill until such time as the Ministry of Education was able and willing to build a health promotion culture within schools, with a possible future shift in funding school health promotion initiatives from Vote: Health to Vote: Education. Earlier in the 1990s, the Public Health Commission had turned its attention to 'health settings', with schools identified as one such setting for health promotion. In a policy advice paper to the Minister of Health issues such as 'school environmental health, support for curriculum initiatives on school health education, the Healthy Schools programme, programme and resource evaluation, and personal health care delivery in schools were outlined' (Pears, 1994).

At this stage, it seems that health promotion discourse was going in one direction, from Health to Education. In Chapter Three we saw the extent to which the health sector health promotion discourse was becoming part of the education sector's health education discourse. This was, I argue, to a large extent contingent upon the conditions set in place by the Ministry of Health's policy directions.

By the late 1980s, most Colleges of Education had employed lecturers in health education, to prepare students to be able to deliver the 1985 health education syllabus. With the exception of one College where the lecturer came from the public health sector, all lecturers came directly from education. I would argue that this meant that

generally Colleges of Education health education lecturers were not using a health promotion discourse, but were instead using pre-Ottawa Charter health education discourses, especially as enunciated by earlier health education syllabi.

These discourses are described and analysed in the following chapter.

As we have seen, health education had, by the 1990s, not been eliminated from the field, but rather, as Holman (1992) observed, had become positioned within the broader framework of health promotion as a major component within the wider scheme of things and making a substantial contribution to the achievement of health promotion goals.



## **Chapter Five**

### **An Early Archive**

In Chapter Four the case began to be built for an argument that broad health promotion discourses were being used within public health prior to being adopted and used in education and schools. During the late 1980s and 1990s, the health sector in New Zealand was using health promotion as a broad umbrella term to include a wide range of strategies, including education, that promoted the health and well-being of individuals or populations. The discourse is socio-ecological. It marginalises individual behaviour-change and education in favour of social and environmental determinants of health, community development and health promotion. Aspects of this discourse are discernable in Health and Physical Education in the New Zealand Curriculum (Ministry of Education, 1999). However, for whatever reason, the curriculum discourse places greater emphasis on individual knowledge, attitude and behaviour change than is evident in the public health discourse. This chapter moves further back in time and explores health education and health promotion discourses prior to the Ottawa Charter.

#### **Public Health directions in health promotion**

Prior to 1986, professionals working in the field of health education/promotion in New Zealand tended to be called health educators, not health promoters, and most, both in schools and in public health, held qualifications in education or teaching. In 1984/1985 the then Department of Health recruited health educators from Singapore and the United States with post-graduate qualifications in health education to begin training New Zealand health educators to work within the public health sector. The qualification criteria for acceptance into training were a bachelor's degree and a teacher's certificate. Graduates of the training course became known as health education officers, and worked alongside the public health staff at district health offices. By about 1989, consistent with the discourse of the late 1980s these health education officers had mainly been re-named health promotion officers or coordinators.

In the early 1980s, the Department of Health had established the Health Education Unit, a national unit devoted to the dissemination of health information, and to the education of New Zealanders towards health. During its years of operation, the Health Education Unit produced an impressive amount of health education material to support the work of public health educators and teachers throughout New Zealand. In addition it actively supported the professionalisation of health education officers. It supported the emergence of the Society for Health Education which provided the fledgeling profession with a professional body and a certain professional status within the health sector. The Department of Health had had a long-standing commitment to the training and support of health educators, usually for specific programmes (ie. hydatids prevention), and to the provision of health information resources for the New Zealander public and to schools. The efforts of the Department of Health in the mid 1980s was a further initiative towards its commitment to the development of a health education profession. This was in line with initiatives in other countries, and in direct response to World Health Organisation directions.

These WHO directions were being enunciated through primary health discourses evident in the landmark Declaration of Alma Ata (World Health Organisation, 1978) which proposed that primary health care<sup>23</sup> be seen as a solution to health inequalities. The Alma Ata gave primacy to the notion of intersectoral collaboration, and de-emphasised primary medical care<sup>24</sup> in favour of primary health care. It focussed on the gross social and economic inequalities between nations, and within nations and put emphasis on community development and partnerships (intersectoral collaboration). Health education, with its emphasis on expert knowledge bases and on changing individual behaviour was marginalised in the Alma Ata in favour of the wider social and economic discourse of a health promotion agenda.

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<sup>23</sup> Primary Health Care is general and broad health care that occurs *prior* to hospital intervention

<sup>24</sup> Primary medical care is that clinical care that occurs in places such as GP surgeries.

The year before, at the 30<sup>th</sup> World Health Assembly, the World Health Organisation policy initiative Health for All by the Year 2000<sup>25</sup> (WHO, 1977) was an early formulation of this health promotion position. At this assembly, health was not viewed as an end in itself, nor was it seen as the ultimate purpose of health promotion, but rather it was seen as a means to an end (Ashton and Seymour, 1990). The final goal was now no longer health, but rather was conceived as a socially and economically productive life. For health education, the implications of this formulation of health were to take some time to become apparent. However where previously health education discourse had focussed on moving people closer and closer to the desirable 'state of health', now instead health promotion discourse was focussed on people's lives, their social and economic circumstances with wider social and economic contexts. This discourse was set to become an emphasis and defining characteristic of the emergent health promotion discipline.

### **Education directions towards health promotion**

In the education sector, the then Department of Education published Health Education in Primary and Secondary Schools (1985), a health education syllabus which had been championed by the efforts of the department's curriculum officer for health education, Helen Shaw. Apart from Shaw and a health education lecturer at Loretta Hall (the Catholic teachers' training college), there were no specialist health educators working in the education sector. Health education was not a separate secondary school curriculum subject, and even in primary schools, it was a subject given very little emphasis or consideration by many teachers. Prior to the 1985 syllabus, teachers were working from a syllabus published in the 1950s, with little support in the way of professional development and resource materials. It wasn't until the late 1980s, in response to the need to prepare teachers to use this (new)1985 syllabus, that colleges of education began appointing lecturers with a specialisation in health education.

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<sup>25</sup> From here on referred to as *HFA2000*

### ***The Discourse of the 1985 Health Education Syllabus***

This 1985 syllabus placed both health education and health promotion discourses before teachers, although the health promotion discourses are rather disguised and de-emphasised. In a reversal of the situation with the 1999 curriculum, there is no definition of health promotion but health education is defined. The definition of health education focusses on behaviour as health action rather than behaviour adaptation or change:

Health education is the process through which people develop the understandings, skills, and motivation to act in a responsible way for their own health and the health of others (Department of Health, 1985:4) [*Italics added*].

There is an understanding that health education is an educational process that leads to understandings, skills, and motivation to act. Health education is first and foremost to do with education and learning, with educational (teaching and learning) strategies and knowledge being applied towards health outcomes. Secondly health action, extending beyond action which may benefit the self, to action that will benefit others is considered part of health education. This broadly social imperative imposes a moral overlay in health education discourse, resisting (neo-liberalist) individualistic discourses which were becoming more evident in New Zealand at the time. The syllabus definition includes the notion of education for health. Health, under these definitions, is seen as an ‘end’ and as a ‘good’. It is valued, something worth striving for, worth attaining. As a consequence of this view of health, health education can be viewed as a worthwhile, even a moral enterprise, because of its role in moving people towards this ‘good’. Health education discourse, at least in the syllabus definition, places moral expectations on people to act in ways that they may not have acted had they not had that expectation placed on them. One could argue that they can still decide whether to act in the interest of others, but there is a subtle imperative at work in this discourse.

The syllabus’ title, its definitions and its approach emphasise health education discourses as discussed and analysed in Chapters Three and Four. The syllabus’ approach “emphasis[es] the attitudes and practices that contribute to a healthy lifestyle” (Dept.of Education, 1985:5) and which develop “responsibility for health” (ibid.). The discourse of

the syllabus rests on two key definitions, those of health and health education. In line with the 1946 WHO definition of health, the syllabus definition of health is holistic (“physical, mental, and social health”) (1985:4) and is equated with well-being. The stated aim of the syllabus is “to enable students to understand the basic requirements of good health, to develop a sense of responsibility for their own health, and to take constructive action for personal health, for the health needs of others, and for health issues in the community” (ibid.). It’s general objectives are designed to help students “acquire knowledge and develop the attitudes that contribute to healthy living...develop the skills needed to establish healthy practices and maintain health, [and] apply the knowledge and skills in their everyday lives”(ibid.).

Whilst a health education discourse dominates the syllabus, it is complemented with an under-stated but clearly recognisable health promotion discourse. Teachers are advised that health education will be more effective when they “promote health in a variety of incidental ways” (Dept. of Education, 1985:9). There is emphasis on the involvement and support of the wider school community in the development of health education programmes, which “are seen as an integral part of health promotion in a wider context” (ibid.:8). The involvement of parents and community health workers in health education programmes is seen as “a means of linking school programmes with health promotion in the community” (ibid. p.10). While this may suggest that health education happens in schools and health promotion in the community, there is a topic within the syllabus that encourages students to gain an understanding of how communities are responsible for health, and encourages them to become actively and responsibly involved in community health issues.

These specific references to health promotion are enhanced by a dynamic discourse of community, social action and environmental awareness in relation to human health. The nine themes<sup>26</sup> which define the content of the syllabus include two that specifically use this broadly socio-ecological discourse: the theme Finding Out About Helping Agencies in the

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<sup>26</sup> The nine themes of the syllabus are: Building Self Esteem; Relating to Others; Eating for Health; Physical Activity for Health; Staying Healthy; Caring for the Body; Keeping Safe; Finding Out About Helping Agencies; and Having a Role in Community Health Issues.

Community has an emphasis on enabling students to make appropriate use of community services; and the theme Having a Role in Community Health Issues specifically encourages students to become involved in community health issues and “to take an active role in meeting the health needs of others” (Dept. of Education, 1985:13). This use of a health promotion discourse in the syllabus is an important contingency for health promotion discourses to be able to take a more dominant position in the subsequent 1999 curriculum statement. They make such discourses available to teachers, so that their use in the later curriculum is already familiar.

### **Other health education/promotion discourses**

As was becoming apparent through the analysis in the last chapter, the theoretical underpinnings of the discipline at this time emphasise psychological theory especially theories of individual behaviour change, and educational and learning theory, with an emphasis on educational planning and evaluation. Educational theories are too broad to attempt to review in the context of this thesis. They are well reviewed, in the context of health education, by Tones and Tilford (1994) who provide a comprehensive coverage of the educational underpinnings of health education and health promotion. Later in this chapter I discuss how salient aspects of psychological and educational theories are consistently drawn upon by health education practitioners in the development of health education theory.

#### ***Health Education as the ‘umbrella’ term***

Ewles and Simnett (1985) see health education as the basis for health promotion. Unlike later writers such as Tones (1996), they do not accept the legitimacy of health promotion as a discipline, instead seeing health promotion as a ‘goal of health education’. Their brief discussion of the ‘recent’ term health promotion:

includes traditional health education...but...may refer to the marketing / advertising aspects of health education, or the political aspects of lobbying for changes in health policy or legislation, or to changing health policies at local level. Finally,

it is sometimes used to refer to the emphasis on positive health, as opposed to the negatively-flavoured prevention of ill-health (p.29).

Other health education writers at this time were discussing how radically health education ideas had changed, and there was wide debate about the business of promoting health (Coutts & Hardy, 1985). Ewles & Simmet's health promotion discourse is positioned against health education as a recent, emerging concept or approach. Certainly, the discourse of health promotion was being discussed as 'emerging' or 'recent'. However, I argue that an approach which resembled the post-Ottawa Charter health promotion approach was already a familiar one for public health workers in New Zealand at this time, but without the surefooted or common use of the term health promotion. Health department policy analysts, medical officers of health, health protection officers, dental officers and public health nurses, had, for many decades, been involved in the approaches like those outlined by Ewles and Simmet. They had, as a public health workforce, been involved in marketing and advertising health messages (health education), and had, over the course of the twentieth century been actively working in communities, and lobbying local and national governments for policy changes conducive to health. By 1985 a greater emphasis on positive health in health education was being promulgated by the public health workforce alongside traditional preventive messages.

Prior to the Ottawa Charter, health education writers such as Ewles and Simmet (1985) and Coutts and Hardy (1985) see the goals or objectives of health education as health consciousness, knowledge, self-awareness, attitude change, decision-making, behaviour change and social change. They are mindful of the determinants of health such as poverty, and are aware of the role health education can play to raise social consciousness of such issues, as well as the need to work towards changing such conditions. However, they position the goal of social change behind health education's other goals. There is general agreement that health education is concerned with the prevention of illness and injury: "in reality, what prevents disease promotes health and vice versa...disease prevention is an integral part of health promotion" (Coutts & Hardy, p.4). Ewles and Simmet see health education "positively improving the quality of health and thus the quality of life" ( p.27). These writers view health as holistic and as a process, and they express concern with the

ethics of behaviour change, both at the individual and community level. However, they do emphasise the importance of 'creating healthier conditions for everybody'. The promotion of health is the responsibility of a variety of agencies as well as individuals themselves:

The health status of individuals or of communities may be influenced by a planned strategy directed at health promotion. One of the [ ] main ways of influencing the health of a community is health education, which is a planned process aimed at helping individuals and communities achieve and maintain a level of health which is appropriate for them. Many different types of activity are labelled 'health education'. For this reason the term may be considered as an umbrella which encompasses a number of activities concerned with promoting the health of both the well and the sick (Coutts & Hardy:14).

Health education activities, the purpose of which is to promote health, include community and school health education programmes and media health promotion. The "basic tenet of all health education is, first, that personal or collective behaviour influences health status and, second, that it is possible to change the health-related behaviour of individuals or communities by planned purposeful activity" (ibid.:15). Health education is described as "a multifaceted activity, employing a variety of means and strategies to deal with the promotion of health in society....[Its] main approaches...are information-giving, education, propagandising, enabling strategies and political action" (ibid.:21).

So it can be seen that in 1985 health promotion and health education discourse favoured health education at the expense of the (emergent) health promotion. In support of this, the National (U.S.) Task Force on the Preparation and Practice of Health Educators (1985) emphasises health education discourses. Health education is the process of assisting individuals, acting separately or collectively, to make informed decisions about matters affecting their personal health and that of others. Writers such as Ewles & Simnett (1985) and Coutts & Hardy (1985) see health education as the umbrella term. They are willing to entertain the term 'health promotion' and use the term in discussions such as those around the role health education plays in the promotion of health. They agree that health

promotion strategies need to include education, but recognise that they are more wide ranging than health education, even to the extent of including political action. Coutts & Hardy's observation that there is wide debate about 'the business of health promotion' indicates a lack of agreed rules for the use of the term at the time. In lieu of an agreed rule, the default rule seems to be that health education discourse includes all of the above.

Slightly earlier in time, Ross & Mico (1980) use the discourse which we have already encountered in the 1985 syllabus, that of health education being active. Amongst the features of health education in action, Ross & Mico talk of the need to understand or improve a 'situation of concern'. Actions "are undertaken to bring about changes either in people's behavior (sic) or in their environment [and] those who will be affected by a change effort are involved in the planning and implementation activities" (p.6). Of interest is the inclusion of a list of health education terminology developed by eminent health educators in the 1970s. The list was developed because of the belief that agreement on the meaning of language would enable health education practitioners to communicate effectively with one another and with the community. In a sense, the list was an attempt to define the rules that (then) governed the use of health education discourse. It included a wide range of health education terminology such as health instruction, health information, and school health education. Absent from the list is the term health promotion. However the list does include such terms as consumer participation, health environment and macrosystem, all of which are aspects of the (now) familiar later health promotion discourses. This indicates that Ross and Mico, like Ewles and Simnett, saw health education as a broad umbrella or dominant term. Alternatively, their desire to 'pin-down' health education discourse may well have been in resistance to the emerging health promotion discourse that threatened the dominance of, and discipline of health education at the time.

### **Education discourses in health education/promotion**

In Chapter Four I indicated that education theory and models were more prevalent in health education/promotion discourse in the 1970s and 1980s. The following analysis of this discourse attempts to clarify the discursive rules that allowed such discourse to be used by health educators/promoters of the time.

The field of education provides health education with several useful discourses. For instance, the educational discourse of planning is taken up by several writers of the time. Health education is defined as “an educationally oriented process of planned change which focuses on those behaviors (sic) or problems that directly or indirectly affect people’s health” (Ross & Mico, 1980:7). Education theory provides planning models with which to systematically plan health education interventions. The processes involved in using such planning models aim to influence people’s behaviours by producing changes in their knowledge, attitudes and skills (Kemmer & Close, 1995).

One health education planning model, the PRECEDE<sup>27</sup> model or framework (Green et al., 1980) provides perhaps one of the most cited definitions of health education of this time:

Health education is any combination of learning experiences designed to facilitate voluntary adaptations of behavior (sic) conducive to health (p.7).

The components of this definition highlight several key aspects or discursive rules governing the use of the term health education. Firstly, health education focuses on learning. It uses the knowledge of learning theory and the skills of education to provide learning experiences for people in the field of health. It can be differentiated from the (health) education that doctors (and other health professionals) might receive over the course of their health (medical) training, by having as its aim the facilitation of people’s voluntary change to their own health behaviour. Green’s discourse is a liberal one, with no hint of coercion. The health educator is a facilitator. People are free agents, able to decide whether they will make ‘adaptations’ to their behaviour in response to the learning they may have experienced. However, not all health educators at the time shared this liberal stance.

In contrast, an ‘interventionist’ approach is enunciated by Simonds (1976). Such an approach is based on the view that health education brings about behavioural changes in individuals, groups, and larger populations. These behavioural changes move people in a

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<sup>27</sup> “PRECEDE is an acronym for predisposing, reinforcing, and enabling causes in educational diagnosis and evaluation” (Green *et al.*, 1980:11).

direction 'conducive to present and future health' and away from behaviours that are presumed to be detrimental to health. It stands in opposition to the liberal stance that maintains the view that health education must not be "propagandistic, manipulative, coercive, politically or commercially directed, threatening, or paternalistic" (Green et al. 1980:9). While acknowledging the moral imperative of such a stance, they acknowledge the educational basis of such a position (eg. needs-based educational intervention and the importance of ongoing evaluation), as well as its psychological basis:

The evidence that the durability of cognitive and behavioral (sic) changes is proportional to the degree of active rather than passive participation of the learner is overwhelming (ibid.:8-9).

Writers such as Green et al. believe that such a position is advised for other practical and strategic reasons, warning that public resistance to health education programmes occurs when the health educator ignores the need to ensure voluntary and active participation of the learner. This aspect of voluntary and active learner participation leads directly to another broad area of educational theory used extensively by health educators, motivational theory which in turn draws on the field and discourse of psychology.

### **Discourses of Educational and Health Psychology**

Health educators are interested in what motivates a person to want to learn. The question 'How can educators ensure that their planned intervention will be willingly embraced by the learner?' lies at the basis of theories of human motivation. Various theorists have attempted to address this question, with health educators taking most interest in behaviourist, stimulus-response theory (Thorndike, 1898; Watson, 1925; Skinner, 1938; Hull, 1943), cognitive theory (Tolman, 1932; Lewin, 1935, 1936, 1951; Lewin, Dembo, Festinger, and Sears, 1944; Ausubel, 1968), humanist theory (Rogers, 1969) and adult education approaches (Knowles, 1978) to learning. More recently, the health promoters Kemm and Close (1995), Glanz et al.,(1997) and Nutbeam and Harris (1998) provide succinct summaries of how health educators use such theories.

In this area of human motivation to learn and to change, health education discourse draws heavily on psychological, especially health psychology theories to better understand individual health behaviour and to explain how individuals can be influenced and motivated to change their health behaviour. Psychologically-based theories and models developed in the time preceding the Ottawa Charter and used frequently by health educators and health promoters in planning their programmes include the transtheoretical model (Prochaska & DiClemente, 1984; the diffusion of innovation theory (Rogers, 1983); the theory of reasoned action and the theory of planned behaviour (Ajzen and Fishbein, 1980); and the health belief model (Hochbaum, 1958; Rosenstock, 1960, 1966, 1974; Kirscht, 1974; Becker, 1974). The following brief review of these theories provides a rich source of health education discourse being developed and used up to, and around the time of the Ottawa Charter. They indicate the strong hold psychological, individual behaviour-change discourses have on health education at the time.

Also known as the Stages of Change model, (Prochaska & DiClemente, 1984) Prochaska's transtheoretical model focuses on the process of change, identifying stages of change that people predictably go through when making changes in their health behaviour. Prochaska's stages are: precontemplation, when the individual has no intention to change; contemplation, when the person begins to think about changing a specific behaviour; determination, or preparation, when a commitment is made to change; action, when behaviour change begins; and maintenance (or relapse), where the behaviour is either sustained or fails to be maintained. The model is useful in helping practitioners design interventions that assist people to move from one stage to the next, and reduces the frustration often experienced in health education/promotion when people fail to make the desired behaviour change. In addition, it allows practitioners to work with individuals, recognising the stage they might be at. The theory's discourse suggests that appropriate intervention is more likely to occur with this individual focus, leading to a greater chance for positive health outcomes.

Whenever health promoters wish to introduce new knowledge or behaviour for health (often resulting from empirical medical research) it is useful to understand how such knowledge is spread (or diffused) within the population. The diffusion of innovation theory

grew out of work by Rogers (1983) as he studied how new agricultural ideas or innovations are diffused within farming communities. He found that there are certain factors that determine the success and speed with which new ideas are taken up by communities. Factors such as the characteristics of the people in the community, the rate of adoption, the nature of the social system, the nature of the innovation, and the characteristics of the change agents (Nutbeam & Harris, 1998) need to be considered. There are always some people who are quicker than others to take up new ideas. For instance the idea that we should expect all indoor spaces to be smoke-free is one that illustrates Rogers' theory. He found that the rate at which people take up an idea, say the idea of smoke-free environments, can be speeded up by 'selling' the idea in certain ways: it needs to be seen to be compatible with existing societal values (eg. non-polluted environments, or not doing harm to others); there needs to be a perceived advantage in the new idea (environments will be more pleasant, building cleaning costs will be lower, or cancer rates will decrease); the idea should not be complicated or overwhelming (changes will not involve expensive building requirements); people need to feel they can easily return to their old ways if the new idea proves untenable (a simple law change, and the removal of some signage); and it helps if those presented with the innovation can see people already successfully using the new idea (many smokers already seem happy to retreat outdoors for their cigarette and non-smokers are polite in asking smokers to smoke outside). Rogers found that there are those who lead the way with an innovation, showing others that it is possible and beneficial. Then the majority of people come on board, leaving a small minority who remain unconvinced and resistant. However, if all of his 'selling' ideas are taken into account, this small minority will also dwindle over time as they daily face the pressure of the growing majority against them.

In a similar way to Rogers (1983) who acknowledged the power of the majority to shape the behaviour of the minority, Ajzen and Fishbein (1980) developed their theory of reasoned action and planned behaviour based on the assumption that people are usually rational, and will act on their beliefs, especially if there is social pressure to do so. Consequently, the theory helped shape programmes such as youth anti-smoking programmes, where short-term negative consequences such as financial cost or offensive personal odour are emphasised, along with utilising significant others to ensure positive

peer (social) pressure not to smoke. The theory highlights the importance people place on perceived social norms and suggests that people's behaviour is influenced by knowledge of short-term consequences.

Earlier, in the 1950s, a group of American social psychologists attempted to explain why it is that people fail to participate in preventative health programmes or fail to comply with doctor's orders, even in the face of diagnosed illness. Hochbaum (1958) and Rosenstock (1960), and later Rosenstock (1966, 1974), Kirscht (1974) and Becker (1974) drew upon learning theories derived from psychological theories such as behaviourist, stimulus-response, and cognitive theories developing what became known in health education as the Health Belief Model. The model predicts that people "will take action to protect or promote health if they perceive themselves to be susceptible to a condition or problem, and if they believe it will have potentially serious consequences", that is, if they believe that there is a perceived threat. The theory suggests that people will take action if they "believe a course of action is available which will reduce their susceptibility, or minimise the consequences, and that the benefits of taking action outweigh the costs or barriers" (Nutbeam & Harris, 1998). The model was effective when used for the purposes of rather simple preventive health situations such as adherence to health checks, or the maintenance of immunisation schedules. It has been a less useful model when applied to long-term, complex and socially determined behaviours such as weight control or drug use, but it does highlight the importance of promoting changes in health knowledge and beliefs. Consequently, it is almost always a consideration in comprehensive health promotion programmes during the 1960s, 70s and 80s.

These educational and psychological discourses emphasise health behaviour change, either clearly and overtly (as in Green's and Simonds' definitions) or less obviously (as in the National Task Force's discourse of 'informed decision-making'). They focus all on health behaviour. Health education discourse includes the discourses of learning experiences (Green, 1980), informed decision-making (National Task Force, 1985) and action, either specifically (National Task force) or inferred (Green, 1980; Simonds, 1976). There is little evidence of a discourse of positive well-being or promotion, but there this is an emerging

discussion of the (new) term health promotion. The dominant discourse at this time is a health education, not a health promotion one.

### **Health Education as the dominant discourse**

The use of the term health promotion has been emerging, I argue, out of health education discourses, public health and primary health discourses. As we go back further in time, health promotion is barely heard. Health education discourse is able to do the work of 'promoting' health.

Greenberg (1978) describes the factors that he believes identify excellent health education programmes:

They provide for instruction to occur outside, as well as inside, school walls [and] they involve students significantly in the learning process (p.256).

He sees health educators as 'instructors'. However, in his discussion of the role of the teacher in health education, he prefers to see the teacher being transposed from "being active (lecturing)" to "helping others be meaningfully active (process leader, facilitator of learning)" (ibid.:257). The health educator uses learning activities which actively involve learners in their own learning "by requiring them to uncover information, draw inferences, identify feelings, or discover insights by their own actions" (ibid.). Health educators, according to Greenberg:

will be available to students to help them achieve their objectives in an interesting and educationally sound environment. Particular behaviors (sic) will not be predetermined as healthy, with students programmed to behave accordingly; rather, students will investigate the values systems they are (sic) and, with knowledge of themselves and health content, within societal limitations, determine for themselves what is healthy for them (ibid.:258)

The humanist position enunciated by Greenberg emphasises a rhetoric of individual choice and self-interest, important contingent discourses for health educators working in the later neo-liberal decades in New Zealand. According to Greenberg, the freedom that students have in determining health for themselves is limited only by society, (whatever that may mean). Hints of post-modern discourse are also evident in Greenberg's writing, with his willingness to acknowledge multiple realities and values systems, and non-prescribed definitions of health. In addition he includes a discourse of community participation and the need for health learning to occur in wider community contexts. The discourse does not, as it does in the later archive, focus on community capacity, development or empowerment, but rather focusses on learning occurring within the community. The focus is clearly an educational one, not a community-development one.

### ***Education sector discourses***

In the education sector during the 1970s the Department of Education had initiated some controversial debates regarding social, health and relationships education, with the public release of the report of the Committee on Health and Social Education, Growing, Sharing, Learning (Department of Education, 1977)<sup>28</sup> and a discussion paper, Human Development and Relationships in the School Curriculum (Department of Education, 1973)<sup>29</sup>.

### ***The Johnson Report***

The Johnson Report is a comprehensive and detailed discussion of "a number of concerns that had been in the public mind over a number of years" (Department of Education, 1977:6). The National government's manifesto had referred to the promotion of 'sound family relationships' and adaptability to change, with Gandar, the Minister of Education, expressing his desire that the committee discuss a "wide range of social concerns and moral issues, in a context of life-long education" (ibid.). The committee was charged with exploring the relationship between schools and the wider community, because of the view that issues such as the breakdown of the family unit, ex-nuptial births, venereal disease, the road toll, television violence, truancy, poor parenting, child health, mental health, drug

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<sup>28</sup> Usually referred to as the Johnson Report, after its chairman, J.G.Johnson.

<sup>29</sup> Usually referred to as the Ross Report, after its chairman, Mr J.A.Ross, superintendent of the Curriculum Development, Department of Education, Wellington.

abuse and Polynesian urban migration were 'wider than programmes in schools'. Consequently, the report ranged over all of these issues, recommending a large number of actions, many of which related directly to health education.

At its outset, the committee adopted a Central and Scottish Health Services Councils (1964) definition of health education:

Health education means different things to different people. Traditionally, it has been mainly concerned with giving information and advice about factors which promote physical health such as fresh and clean air, hygiene, exercise and nutrition. But increasingly it has covered advice about mental health and such topics as sex education, marriage guidance and family and social problems which may play a part in determining health or disease. In this wider sense there is hardly any aspect of life which can be excluded from the ambit of health education. This view...is reflected in the definition of health adopted by the World Health Organisation, namely, a state of complete physical, mental, and social well-being, and not simply the absence of disease or infirmity (Department of Education, 1977:11),

and a 1969 WHO Expert Committee definition which introduced many of the (now) familiar discourses of health promotion:

The focus of health education is on people and on action. In general, its aims are to persuade people to adopt and sustain healthful life practices, to use judiciously and wisely the health services available to them, and to take their own decisions, both individually and collectively, to improve their health status and environment (Department of Education, 1977:11, *my italics*).

The first definition uses an 'advice and guidance' discourse, the second an 'action and persuasion' discourse. Both focus on personal health practices, with the WHO definition adding collective action to improve the environment. The Johnson committee adapted these definitions for its report, stating that the aims of health and social education are:

to equip parents and teachers to promote the positive physical and mental health of themselves and of their children; [and] to equip children to grow more and more responsible for their own health and to act morally towards other people (Dept.of Education, 1977:12).

The report looks at health and social education, with one of its major recommendations being the development of health and social education programmes in schools (and the community). This would include moral, spiritual and values education, human development and relationships education (including sex education), outdoor education, physical education, and drug and alcohol education. It saw such programmes being effective when supported by ‘effective’ school climates, school-based guidance services, recreation and leisure programmes, teacher training, parenthood education, neighbourhood development, the extension of health services to schools, and a substantial reduction of television violence. The WHO discourse of environmental improvement is not evident but does include the responsibility of students to consider other people.

#### *The Ross Report*

The earlier Ross Report of 1973 was responding to widespread concerns about the “relative responsibilities of the home and the school for the personal and social development of young people” (Department of Education, 1973:5). Its purpose was to produce guidance on the subject of health and social education, including suggested teaching programmes whose content would cover psychological development, human physiology, reproduction, conception, pregnancy and childbirth in the contexts of physical, emotional, intellectual growth and moral behaviour. The committee made some ‘basic assumptions’ about health and social education as an aspect of the current (at the time, 1958) health syllabus. It saw the school and parents in a partnership in the provision of health and social education, with the main influence of parents being ‘determining social and personal attitudes and values’, and schools ‘providing accurate and detailed knowledge’. As well, it recognised the influential role of community groups on the social and personal development of children.

Earlier in this chapter, I suggested that at the time of the Johnson and Ross reports, the public health workforce had been using discourses and approaches similar to what we now

call health promotion. In contrast, these two education sector reports devote themselves to educative solutions and discourses. However, they do both talk of societal concerns, of school-community partnerships, and the need for health education to take account of wider social factors in relation to health.

#### *Other Health Education discourses*

Social-environmental discourses were being expressed within education in New Zealand at the time. Irwin, a physical educator at Hamilton Teachers College enunciates such a position as early as 1975. He sees health education relating to “the individual, his close community, and his wider community” (1975:2) and that these aspects should be “quite naturally integrated into our total pattern of living” (ibid). He indicates an understanding of public health, and of comprehensive school health programmes which go beyond curriculum:

While the objects of the school health programme and the public health programme may be the same, they have a different focus for their action. School health education places its focus on the individual, whereas the primary focus of public health education is the group (ibid.).

Irwin provides a strong ‘instruction’ discourse in his description of classroom health education, emphasising its role in behaviour change and the prevention of health problems, as well as highlighting the importance of decision making and the preparation of students for a changing world. However, in addition, he takes a great deal of care in explaining an ‘integrative’ view of health, discussing in detail how the “interdependence of our microcosmic internal world with our macrocosmic external world” (ibid.:11) gives us our ‘unity’. “We are not separate, but an integral part of our world”(ibid.). Irwin talks of dimensions of personal health - physical, mental, spiritual and social - indicating their interdependence and interrelationships. Drawing on the work of Hoyman (1965), he discusses the determinants of health as ‘a network of behavioural, hereditary and environmental factors’ interacting to create a ‘human ecology’. However, there is unfortunately little evidence in Irwin’s very detailed suggestions for teachers, on how an

understanding of this approach can influence a teacher's health education programme beyond individual behaviour change.

*The 1969 handbook and the 1958 Health Education syllabus*

Irwin's writing comes at a time when teachers were using the syllabus Health Education in Primary Schools (Department of Education, 1958) along with a 1969 handbook of suggestions for health education to guide their classroom programmes. This handbook provides a wealth of ideas for teachers to plan and teach health education programmes aimed at providing health knowledge, attitudes, practices and habits. It also recognises the importance of environment and health, giving teachers suggestions for working with parents, and for being aware of a 'healthful' school environment, both social and physical. It was published to provide support for teachers for implementing the 1958 syllabus.

The syllabus' aim was to "create in the pupil's mind a right attitude towards health, and a full sense of its value to himself both as an individual and as a member of society" (Department of Education, 1958:1). Health education should ensure:

- (a) The formation of health habits.
- (b) The development of the right attitude to health.
- (c) The acquisition of health knowledge. (Ibid).

This [knowledge, attitudes, skills] aim would succeed when the child, the parents and 'officers of the Department of Health' co-operated together to achieve it. Teachers were encouraged to systematically plan contact with parents, exchange information about the child, organise parents' gatherings and school 'open days', and invite parents to school medical inspections. They were urged to work closely with the Department of Health, 'particularly its Division of School Hygiene', making full use of its posters and pamphlets and background reference material for 'use in health lessons'.

This discourse of knowledge, attitude and skill acquisition and community involvement is similar to the later syllabus and curriculum discourses discussed in Chapters Three and Four. The teacher is positioned quite clearly as one side of a triangle in co-operation with

parents and the Department of Health. This triangle was seen as a crucial factor in ensuring the effectiveness of classroom health education. The language is simple and direct. It lacks the jargon of the 1999 curriculum's 'underlying concepts', expressing the idea of intersectoral collaboration more evident in public health discourses than the 1999 curriculum's discourses of health promotion and socio-ecological perspectives. Absent from the 1958 syllabus is any obvious discourse of social or environmental determinants of health, other than this recognition of the value of cooperation between the three sides of the triangle. Rather, the discourse emphasises, as I have said, knowledge, attitude and skill acquisition and the teaching of temperance, or "the avoidance of any over-indulgence" (p.2). Lessons should teach the 'joy that comes from a perfectly sound healthy body', the function and development of the body, sound mental health (eg. a sense of security, self-expression and group well-being), the formation of health habits, and the prevention of disease.

The 1958 syllabus was written at a time in New Zealand's history following the trauma and upheaval of the Second World War. The nation was re-building itself, re-populating and trying to forget the negativity and tragedy of the war years. After the huge loss of life (most communities had lost large numbers of their young men), the hope of life in the future was seen to be in the children, and in their carefully nurtured development. Such a background of hope for the future, and an acute awareness of the preciousness of life following such loss, provided a context for the discourse of this syllabus and for the formation of its discursive rules. Communities had learned during the war years to 'pull together' and to rely on one another. The sense of co-operating in networks or 'triangles' of care and concern would have seemed eminently prudent in the context of a health syllabus where the welfare of (precious) children was at stake. The excesses of Nazi Germany (as well as the closer-to-home experiences of Kiwis' war-time alcohol abuse) had been a lesson to many New Zealanders about the evils of intemperance and over-indulgence. And the need for 'perfectly sound healthy bodies', able to respond to the rigours of war or to the strictures of war-time rationing and hardship had been well demonstrated over the war years and the earlier Depression. The overtones of militarism, authority and 'preachy moralism' in the discourse of the syllabus are understandable given the state of New Zealand at the time. The rules that made it possible for these older discourses to have been dominant and favoured are ones that ensured children would be prevented from making the kind of

mistakes that had led to the kind of evil that their parents had just witnessed. Adult New Zealanders were new serious in their attempt to train a moral, sound, and disciplined generation of children. They knew better than their children, and they were taking their parenting responsibilities seriously. With such a view, there was no room for encouraging children to take responsibility for their own health or the health of others, decision-making, community health action, or policy development. The triangle of adults would do this on behalf of children, and in the best interest (they believed) of children.

And so, having worked back through the archive from the present, describing the various discourses in detail, I have arrived at a point where this 1958 discourse sounds (to the ears of a present-day health educator) quaint and old-fashioned. Much of the 1958 syllabus discourse has been substituted by other discourses in the intervening period of time. Sarup (1993) had indicated that this would occur if the method of analysis of going backwards into the past was used. In Chapters Three, Four and Five I have attempted to describe health education and health promotion discourses in the archive until a difference has been detected. The next final chapter re-covers the same ground with the expectation (based on Sarup) that an exploration of the older discourses and practices will show 'their negativity in relation to the present' discourses, and explode the rationality of these presently favoured, taken for granted discourses. This final chapter, then, attempts to find the rules that made it once possible for the older discourse to have been dominant and favoured, and to understand the new rules that have allowed the current discourse to be perceived as so rational, so 'right'. In doing so, Foucault's project of 'exposing the historical specificity - the sheer fact that things could have been otherwise - of what we seem to know today with such certainty will have been achieved. The past will have been broken off from the present, demonstrating the foreignness of the past, and relativising or undercutting the 'legitimacy of the present'.

...the extent that history serves to show how that-which-is has not always been; i.e., that the things which seem most evident to us are always formed in the confluence of encounters and chances, during the course of a precarious and fragile history...It means that they reside on a base of human practice and human history; and that since these things have been made, they can be unmade, as long as we know how it was that they were made (Foucault,1990:37.)

## **Chapter Six**

### **Discussion and conclusion**

I begin this chapter with a discussion of my experience of the research process, how using a Foucauldian analysis has both excited and challenged me. In doing so I will talk about some of the difficulties involved in such an analysis.

Chapters Three, Four and Five took us back into progressively earlier and earlier health education discourses until, in the 1950s, a curriculum discourse was arrived at that now seems quaint, old-fashioned and out-of-place in the context of the present health education curriculum. I return to the discourses of these three chapters, discussing the discursive shifts, emphasising the changes in discursive rules, and highlighting contingencies that may have played a part in the formation of these rules. I do this by briefly attending to a 'checklist' developed by Kendall & Wickham (1999) which ensures that the techniques of archaeological analysis been fully utilised. Finally this chapter returns to the research questions, indicates how the analysis has helped address each question, and suggests directions for future research.

#### **The Research Process**

Analysing an archive from the present to a point in the past, whilst keeping a 'problem' constantly before me, has been a fascinating experience, and one that I could not fully understand until I had been through the process. The following is a discussion of this process, some of the problems encountered, and how it affected the way I wrote the analysis. As such, this section is more reflexive in style than the earlier chapters.

#### ***Problems***

Several problems emerged as the analysis progressed, forcing me to re-consider the way I was engaging with the archive, and the way I was writing the analysis.

### *Knowledge of the Unearthed Past*

The most difficult problem to overcome was knowledge of the older, 'unearthed' archive. This presented itself in two ways: (i) many of the writers whose work I was analysing were referring to older discourses or works from earlier times before I had had the opportunity to uncover discourses from that earlier period in the archive; and (ii) in a similar way, I brought to the project my own professional and personal knowledge of older discourses. Because of the style of analysis these earlier discourses could not be discussed because they were still hidden in the past and therefore ostensibly 'unknown'. It became apparent that I could not talk about these discourses until they had been uncovered systematically during the archaeological process.

I began to find the archaeological metaphor helpful when dealing with this problem. Older discursive layers are hidden by the layers of more recent discourses in much the same way that the evidence of old civilisations remain hidden under the layers of more recent civilisations. Until they are uncovered by the analysis (the archaeological 'dig'), they are, to all intents and purposes, hidden. As I uncovered layers of discourse I could begin to discuss them. I could only talk about the layers I had uncovered in the analysis to that point.

Once I had realised the importance of this archeological problem, I found my style of writing changed. There was a requirement to become disciplined to the task of not talking about discourses that were still to be 'unearthed'. Just because the writers whose work I was analysing were talking about older discourses (these 'hidden' layers), or that I knew them from my own time spent in the field, did not mean I could talk about them or even allude to them. I had to find a way to deal with this. While I have tried to attend to this problem by re-working earlier parts of the analysis and removing reference to older, hidden discourses, there is probably a sense in which the analysis becomes more disciplined as the analysis progresses, or as I became increasing aware of the problem. The various Foucauldian commentators, and Foucault himself, had not prepared me for this. It felt, and still feels like a discovery, and as such, excites me. I found this excitement helpful in developing a writing style to deal with the problem of the unearthed past.

### *Contingencies not influences*

While the Foucauldian commentators and Foucault himself had not prepared me for the first problem, they had prepared me for this one - the urge to suggest that certain contextual events may have influenced or determined the discourse under analysis. Even with the forewarning of the problem, I found this way of working extremely challenging. It is a sharp example of how strongly positivism pulls us when we choose to work in a post-structural way. Positivism urges us to look for explanations and to try and uncover answers and reasons. My uncovering older layers of discourse was not necessarily uncovering any answers or reasons. I found I was constantly having to resist this (positivist) urge to explain and suggest causal links or reasons.

Using the archaeological metaphor again, and adding a geological metaphor of sedimentary and volcanic rock, I found the idea of layers very helpful. The archaeological metaphor shows how people build new buildings and civilisations over the top of older buildings and civilisations. This redevelopment includes similar things (eg. dwellings, churches, streets, decoration and ornament etc), but each layer is distinctively different across a wide range of dimensions. For instance, the building methods may be different, the size and placement of structures may vary, the surface or alignment of roads might differ, and the expression of art may bear little resemblance to other styles.

Even more dramatic is the geological metaphor. When one visits Death Valley, California, or sees a new cutting during roadworks here in New Zealand, the story of the earth's crust is put on display. One can see each new layer progressively deposited on top of older layers. Layers are of different colours, made from different material, and are of different thicknesses. There may be several sedimentary layers, one on top of another, formed by similar material settling at the bottom of an ancient shallow sea. But there may be volcanic layers intervening, providing dramatic differences in colour and texture. As well, layers can be tilted, ruptured, creased and separated, eroded away and deposited in valleys.

Without knowing what was happening on the surface of the earth at the time of layer formation and movement, or without knowing what was happening in the lives of the people during the fall and rise of each civilisation, we can only surmise why certain

geological layers occur, or why aspects of an older civilisation have or have not been incorporated into a new one. To help with such surmising, Foucault's emphasis on contingencies keeps the analyst honest, by reminding her to keep focussed upon the known contextual data of the time. In this thesis, I have concentrated on the contexts which seemed closest to the active discourses of health education / promotion in New Zealand: the development and organisation of the health education workforce; the policy initiatives of the World Health Organisation and the health sector; and to a lesser extent, New Zealand's social and political environment.

*Allowing the discourses to speak for themselves*

Another difficulty has been trusting the discourses to speak for themselves. As I have already said, there has been a tension throughout the analysis to explain or interpret. Instead, I have been forced to trust the 'lamination effect'. I now have to trust that the reader, like me, is convinced of the power of the discourses themselves. The biggest test of this trust was resisting the urge to define key terms such as health, health education or health promotion at the outset. I was determined to allow the changing definitions and usage to emerge with the uncovering of each layer. This became a powerful tool in understanding how definitions are not set in concrete, but change and shift as the discourse changes and shifts.

*Separating archaeological and genealogical analyses vs. weaving them together. When to comment on changes and shifts in discursive formation?*

As I embark on the 'return journey' I have become aware of a problem which can be stated more clearly as a dilemma: should Foucault's techniques of archaeology, genealogy and techniques of the self be undertaken separately, or can (or should) they be woven together as one analytical process?

In Chapter One, as I mapped the philosophy and writing of Foucault, each technique seemed to be doing different, separate analytical work. However, as each of Foucault's techniques was added and explained, I came to the view that he had done this in order to provide more depth and critical analysis to his 'overall' method. This 'overall' method was hidden from view by the examples and discussions of each of its parts. Foucault's

analytical techniques, 'archaeology', 'genealogy of power and knowledge' and 'techniques of the self' are not separate processes, but are rather different aspects of the whole Foucauldian research process. And so, as I began my analysis of the archive, from present to past, from new to old, I set about trying to weave all three techniques in to the analysis from its beginning. This gave me the impetus to discuss discursive rules, context and contingency, power and subject positions throughout the analysis.

There is little help in the literature on how to re-trace back through an archive (from the past to the present). Sarup (p.58) tells us to 'faithfully re-cover the same ground, from the earliest point back to the present'. The task is to 'trace the transformations, taking care to preserve the discontinuities as well as the connections'. In addition Sarup tells us to explore older discourses and practices in such a way that 'their negativity in relation to the present explodes the rationality of phenomena that are taken for granted' (p.58).

When I had completed writing Chapter One, I had thought that the 'going backwards into the past' analysis would involve 'tracing the changes and shifts in discursive formation that are detected'. Having traced changes and shifts in discursive formation as I went from the present to the past, there is a sense in which this work has largely been done. With the knowledge and luxury of hindsight, this 'going backwards into the past' analysis probably needed to be more descriptive, more archaeological, leaving the final chapter to focus upon the critical analysis or genealogy. However, given that I have arrived at this point, my approach to the problem is, firstly to acknowledge it, and secondly to endeavour to be better prepared when I next do a Foucauldian discourse analysis. My aim was, after all, to emphasise an archaeological methodology, so the weaving of a genealogy through the analysis goes beyond the objectives set by my research questions. Having said this, the retracing from past to present, will now as a consequence be briefer than it would have been had I restricted Chapters Three, Four and Five to a description of the discourses and the changes and shifts in discursive formation and rules that were detected.

## **The Return Journey: Retracing the discourses from the past to the present.**

And so, I reach the final stage of the analysis.

To allow the return journey to take some shape, I use Kendall & Wickham's (1999) suggestions for doing archaeological research. As I have explained, the light brush of genealogical analysis has been applied already, but the analytical emphasis of this thesis is the technique of archaeology. Therefore, Kendall & Wickham's 'checklist' of the seven techniques or tools of archaeological research (see Chapter One) are helpful in providing the framework for this chapter and allow me to check that the analysis is thorough and complete.

### ***'Things to do' when doing an archaeological analysis***

Kendall & Wickham (1999) suggest seven things to do when doing an archaeological analysis. I consider each of these seven things and ask whether the work been done in the analysis so far. If it has, I refer to the section or chapter where I have used that particular technique or tool. If not, I go back to the archive and use the technique to provide a fresh way of looking at the discourse. The final three things to do are largely attended to by the first four.

The first thing to do is to understand the relation between the sayable and the visible. In attempting to understand this relationship, the focus of this thesis is on those sets of statements and arrangements that make up the field of health education/health promotion. These sets of statements and arrangements can be found in the 'sayable', eg. policy directives and curriculum guidelines, and the 'visible', eg. institutions, people etc such as the Ministries of Health and Education or schools, and the health education/promotion workforce, and so on. Kendall and Wickham (1999) remind us of Foucault's materialism:

knowledge is composed of the sayable and the visible, or words and things. We need to attend to both what is said and what is visible. The crucial point here is that Foucault draws our attention to the dynamic, mutually conditioning relationship between words and things (p.27).

The authoritarian, paternalistic discourse of the 1958 syllabus which gave no responsibility to students for their own learning or for their own health, and which did not encourage them to make changes to the health environment, can be seen in relation to the way in which schools were organised at the time. Schools were administered by regional education boards with responsibility for decision-making resting with these boards, or with the Department of Education. Adults within a school community were powerless to make policy or environmental changes, and so it would have been unthinkable for students to achieve any position of power within such a hierarchy. As I have discussed in the previous chapter, New Zealand was rebuilding, nurturing its next generation with an over-protectiveness which reflected its great loss of young men in two world wars over half a century. The straight lines of desks, corporal punishment and didactic teaching methods of the time reinforced the nation's desire to rear an obedient, moral and 'sound' generation. The health sector's presence in schools was characterised by Public Health Nurses providing health inspections such as head-lice checks and five year old boys' testicle examinations. The dental clinic or 'murder house' was a very visible outpost of the Department of Health within the school's grounds. Parents (on behalf of their children) were expected to passively accept these services without complaint. Information was expected to be exchanged between parents and schools regarding the health of the child and parents were expected to be present at school-based health inspections. These examples serve to suggest that both the health sector and the education sector contributed to a 'mutually conditioning relationship' between the syllabus' paternalistic discourse and the visibly authoritarian institution of the school at the time.

By 1985, schools were visibly different places from the description above. Student seating arrangements of groupings of desks and tables to encourage student cooperation were common in primary school classrooms. Bare stark floor boards had been covered with carpet, softening the authoritarian and harsh classroom environment. Many schools had been re-designed, re-built or renovated to provide 'innovative' teaching spaces such as open-plan classrooms with more than one [traditional] class and more than one teacher sharing the same space. The social revolution of the 1960s emanating from the United States' west coast had brought into question the paternalism of the 1950s, allowing the discourses of reports such as the Ross and Johnson committees that espoused the need and

desirability of involving students in their own learning, and in taking responsibility for their own health. With physical teaching spaces being re-organised to encourage cooperation and sharing, so too curriculum discourse was encouraging group participation and cooperation. Public health nurses no longer routinely carried out inspections for children's health and development, and instead moved toward supporting teachers in the delivery of the curriculum by providing health education resources, and even taking health lessons. Dental clinics were closing down, with dental nurses servicing several schools from centralised or mobile clinics. The rigidity of the 1950s was disappearing in favour of new innovations and systems. The 1985 syllabus, written in these times of openness, innovation and change could not have been written in 1958, its discourses could not have been enunciated. Again, these examples present evidence of a 'mutually conditioning relationship' between the syllabus' discourse and the visible institution of the school at the time.

In a similar fashion, the most recent 1999 curriculum discourse of hauora, well-being, health promotion and socio-ecological approaches can be seen in relation to the contemporary, self-managing school. The curriculum discourse is complex and daunting. It attempts to strike balances between physical education, home economics and health education, between the individual, society, and the wider environment, and between the politics of the left and the right. It tries to include Māori concepts and approaches, and concepts once thought 'fringe' or 'alternative' such as holism and well-being. It takes on the once-controversial topics of sexuality and drugs, and challenges teachers, Boards of Trustees and students alike to make changes in the school and wider community for health. And it expects secondary schools to make adjustments to subject offerings, timetabling and staffing in order for health to be included as a compulsory subject up to Year 10. And if this were not enough, it rests on the demanding and dynamic processes of consultation, consultation between the school, parents and the wider community about the health education needs of its students.

This complex and daunting discourse is echoed in the complex and daunting environment that is the contemporary school. It is here that teachers juggle curriculum and assessment demands, anti-social, difficult or even dangerous students, parental and BOT concerns,

endless after-school meetings, and vacation-time professional development days on top of the more traditional tasks of planning, teaching and managing the needs of their students. No longer are New Zealand schools under the administrative control of education boards and a Department of Education. They are self-managing (following Tomorrow's Schools, Ministry of Education, ) and as such they are expected to be responsive and answerable to their communities. Within these schools, students are encouraged to be active learners, to critique, question, reflect, analyse and problem-solve. The 'sayable' and the 'visible' are two sides of the same complex and daunting contemporary school reality.

The second thing to do in an archaeology is to understand the relation between one statement and other statements. Foucault's archaeology is essentially interdiscursive in the sense that it attends to more than one discourse at the same time. In the context of this thesis I have attempted to analyse both health education and health promotion discourses together, and have done that by attending to their usage in both the public health and education sectors. To help manage this juggling act, and the relation between one statement and others, Kendall and Wickham (1999) suggest that the analyst focuses on the ordering of statements. Many examples of the ordering of statements have been discussed in Chapters Three, Four and Five. For instance, the contemporary placement of 'health promotion' ahead of health education, the older placement of the two terms beside each other, and the even older placement of health education ahead of the promotion of health is one example and has been discussed previously.

Another way of looking at the ordering statements is tracing a system of statements from their first emergence through the various sites of re-emergence. For example, the analysis has shown how statements of social and environmental determinants of health, and empowerment of people to take critical action for health can be traced from the World Health Organisation, to the Department (or Ministry) of Health, and finally to the education sector, the Ministry of Education, curriculum writers and schools.

Kendall & Wickham (1999) suggest that an archaeological investigation should focus on how such a system of statements works. There are likely many different ways of approaching this. My preference is to return to the discourses themselves as discussed in

the previous chapters. We found that in the 1950s that the term health promotion was not used within the archive. There was, however, a 'health education' discourse used by teachers and by health educators in the public health sector; and there was a 'public health' discourse of prevention of communicable disease, and protection of the public's health. By the 1970's, following WHO policy directives which introduce a discourse of 'promotion of health', the term 'promotion' begins to be used alongside other public health discourses such as health development, community development and holistic models of health. This discourse is used by health educators within public health. In the education sector, the term is used loosely as a synonym for 'encouraging' or 'supporting' health and continues to be used in this way until the 1985 syllabus where it takes on a use closer to the public health discourse. However, as I argued in Chapter Four, the then Department of Education failed to support this discourse with any significant teacher development, allowing it to remain marginalised and largely unused by teachers. Within public health the legitimacy of a discourse of health promotion was given further impetus and credibility with the publication of the Ottawa Charter. In the ensuing years, health promotion discourse developed without resistance, and with support from health educators working in public health, allowing health promotion discourse to replace health education as the dominant discourse. However, in education, health education (individual behaviour change) discourse continued to prevail, and it wasn't until the 1999 curriculum development that the writers were (freshly) confronted with international health promotion literature and the discursive shift that had occurred in public health. Realising, perhaps, that this health promotion discourse was close to their philosophical positions (Chapter Three) the curriculum developers embraced health promotion discourse and included it strongly in the curriculum.

The third thing to do when doing an archaeological analysis is to formulate rules for the repeatability or the use of statements. What is of concern here are the ways in which certain statements (eg. statements concerning individual responsibility for health) can come to be repeated while others (eg. statements to do with 'avoidance of over-indulgence') lose their currency or repeatability. So, what makes certain statements repeatable? Following Kendall & Wickham's (1999) suggestion, I have focussed on the procedures used by Ministries, curriculum writers, teachers, and so forth, to deploy certain statements rather

than others that may be equally feasible. A key aspect of defining the rules that make certain things possible to be said, according to Foucault, is an understanding of the conditions that make them possible to be said. My discussion (above) of the archaeological technique of exploring the relationship between the sayable and the visible provides an example of how conditions within New Zealand made certain discourses sayable, and certain institutional practices do-able or visible.

Another example is the system of statements that were not used in the 1958 syllabus but were in the later 1985 syllabus or the 1999 curriculum. For instance, the discourses of student responsibility for health and for health action are absent from the 1958 syllabus. In more recent times, however, these statements became sayable and increasingly able to be used and repeated. So what procedures were being used to deploy these statements in this way?

One procedure could be the way in which governments influence the ideology of curriculum development. In the 1950s, New Zealand's political ideology was largely left of centre with a highly regulated economy. The State took responsibility for both health and education, providing low cost free health care and free state education. Private health insurance was almost unheard of and unneeded, with the health system able to respond to every aspect of health or medical need. Health education messages were simple, giving sound advice to eat wholesome food, maintain exercise, act safely and morally, and keep good standards of personal hygiene. Parents were charged with ensuring these rules for healthy living were adhered to and taught to their children. The role of the school to support this parental responsibility. It was certainly not seen as the responsibility of children to ensure these rules were met.

By the 1980s, many New Zealanders were questioning such (taken-for-granted) phenomena as social welfare and state asset ownership. Fuelled by economic philosophies emanating from the United States through such 'structural adjustment programmes' as John Williamson's 'Washington Consensus' (Kelsey, 1995), capitalist discourses were being used increasingly within segments of government in New Zealand, especially within Treasury. With the incoming 1984 Labour government, these discourses took firm hold,

and began to appearing consistently in both health and education policy documents. The liberal discourse of 'individuals being the authors of their own fate' and taking responsibility for themselves ensured this aspect appeared in curriculum documents and in the policy documents which preceded curriculum development.

In public health, policies emanating from the WHO reflected ideologies from both sides of the Atlantic. From the European wing of the WHO the discourses were strongly social-democrat, humanistic, empowering and socio-environmental. From the North American wing the discourses were liberal, favouring personal responsibility for health and medical care. A subtle balancing of these two powerful ideologies can be seen in the discourse of the Ottawa Charter, where both appear within the charter's principles.

In New Zealand, many policy analysts working in government departments and ministries performed similar subtle balancing acts, resisting the neo-liberal discourses of government and Treasury, not by excluding them, but by including them alongside humanist and socially-centric discourses. There was less resistance the closer the policy was to Treasury. If the discourses of Treasury briefing papers during this time are strongly neo-liberal, then the discourses of departmental policy papers (*eg. Tomorrow's Schools*) are more likely to temper the extreme neo-liberal discourses of Treasury, making them more palatable to those who might oppose its ideology. Further again from Treasury, the discourses of curriculum documents are increasingly 'resistant', often using the technique of using both neo-liberal and humanist discourses, in much the same way as the discourse of the Ottawa Charter used both European and American discourses. Hence the 1985 syllabus uses both discourses, and so too does the 1999 curriculum.

One of the key foundations of neo-liberalist politics is what Kelsey (1995) calls 'rolling back the state', of limiting the operations, services, assets and functions of the state including even policy and regulatory functions. When the state steps back from social involvement, it suffers a certain loss of control over discourse use, and over social change. No longer involved with hands-on delivery or involvement in community capacity building, the state would welcome the work of a professional group who might carry out this function outside of the direct control or employ of the state. Is the state using health promoters in

this way? Is it actively influencing an independent professional group to further its ideological agenda? In New Zealand health promoters are in the main employed either by the not-for-profit private sector (eg. National Heart Foundation, New Zealand Family Planning Association, Cancer Society of New Zealand) or by the public health services linked to public hospital businesses<sup>30</sup>. My observation is that in this environment, the state is able to present whatever its current political ideology to health promoters employed by public health, through the pervasive circulation of public health discussion and policy documents, and through a system of contracting for service that writes certain discourses into contract specifications. It is less easy to influence the discourses of health promoters working in the not-for-profit sector in this way. However, not-for-profit health promoters often receive their professional development from attending public health sector conferences, seminars and workshop offerings. With regular professional contact between health promoters working in both settings, the discourses of each seed and affect the other. In a position of resistance though, is the health promotion workforce development organisation, the Health Promotion Forum, (a not-for-profit organisation, largely funded by government through service contracts). The Forum provides rich discursive resources which currently resist neo-liberalism. The Forum does this by funding and supporting professional development that actively critiques and resists neo-liberalist discourses.

In education, the link between government and teachers is comparatively close. While teachers are employed by their boards of trustees, they are still required to deliver the national curriculum. The Ministry of Education is therefore in a very powerful position in shaping the discourse use of teachers through curriculum documents and through professional development for teachers which it still largely funds and controls.

The fourth thing to do when doing archaeology is to analyse and discuss the various positions which are established between subjects (human beings) in regard to statements. Throughout Chapters Three, Four and five, I have discussed the way in which statements produce subject positions - ways of being and acting that human beings can take up. The

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<sup>30</sup> Public hospitals in New Zealand were set up as business enterprises in the 1980s, and have since undergone several restructurings and renamings. Public health has had variable and changing linkages with these enterprises following each successive restructuring.

human subject is seen as being simultaneously produced by discourse and as manipulating it. We each hold various subject positions - we occupy various slots such as 'teacher', 'health educator', 'student' and, more intricately, 'effective teacher', 'healthy student', 'critical thinker', 'change agent' and so on. In some of these discussions, I have posed questions that ask whether any subject position is more open to being used to subjugate or to empower, to encourage individualism or social and environmental responsibility. I go back to this issue when I return to the research questions (below).

The final three things to do have been extensively attended to in the analysis of the previous chapters. The analyst needs to 'describe surfaces of emergence' or places within which objects are designated and acted upon (Kendall & Wickham, 1999). In the course of the analysis, many 'surfaces of emergence' have been described, for example the WHO, the discipline of psychology, the Ottawa Charter and the 1985 syllabus. An attempt to describe 'surfaces of emergence' focuses on, say, 'the school' or 'the Ministry' as a domain. Within these domains, curriculum developers, for example, can determine the 'best' learning outcomes for students as special types of educational subject (unfit, mentally unstable, disempowered, or risk-taking etc.), and can, according to Kendall & Wickham, act on students as 'raw materials' (children as healthy individuals, group members, etc.). Chapter Three described in detail the domain of the curriculum as a 'surface of emergence' where the use of certain discourses have determined learning outcomes based on health concerns expressed by politicians and other community watchdogs. The discourses of the curriculum have determined wide-ranging personal health action with the possibility of very real effects on individuals, communities and environments.

An other thing to do in archaeological analysis is to describe those 'institutions' which acquire authority and provide limits within which discursive objects may act and exist (Kendall and Wickham, 1999). This can lead to a focus on 'places of visibility' such as schools, but equally can focus on institutions such as 'psychology' or 'public health' or the WHO. In the above section on the 'sayable and visible' I have discussed architectural features of schools in a bid to understand the contribution these spatial arrangements make to a school's operations. In Chapters Four and Five, I discussed the discursive features of various institutions or disciplines (eg. psychology, marketing, public health, the WHO etc)

and how they have acquired an authoritative role in delimiting the range and existence of health education and health promotion discourses.

Finally, the archaeologist need to describe the ways in which discursive objects are targeted. Kendall and Wickham (1999) refer to this as 'forms of specification'. While I have not used this term in my analysis, I have attended to describing the ways in which discursive objects are targeted each time I focussed on the systematic ways that phenomena such as community action, or individual responsibility are rendered accessible to us through the use of certain discourses. Forms of specification have also been described whenever I have highlighted, for example, how health promotion discourse gives us a vocabulary and a series of concepts that enable the teacher to influence the health action of the student, or to explain the interrelatedness of health actions.

Having reviewed the things that need to happen when doing an archaeological analysis, I now return to the original research questions and indicate whether the analysis has helped address each question, and where it suggests directions for future research.

### **The research questions**

The *problem* of health promotion with a health education curriculum drove this research and helped generate a list of questions that I hoped could be answered by an Foucauldian archaeological analysis. The questions can be found in the Overview (p.2).

#### ***Question One: "Have the two sectors (Public Health and Education) used different discourses?"***

It has been clear from the analysis, that the two sectors (Public Health and Education) have, and do use different discourses. Over the course of the last fifty years, public health has progressively developed and used a 'social and environmental determinants of health' discourse in conjunction with social action and community development discourses. In addition, a broad discourse of health promotion emerged and flourished as a key discourse within public health, and by the late 1980s / early 1990s the discourse of the Ottawa Charter has been in wide use by health promoters in public health. Public health's focus on

populations has made it relatively easy for discourses to shift away from an older health education discourse of individual behaviour change to the more recent health promotion discourse of social and environmental change.

In contrast, the education sector has maintained a health education discourse of individual behaviour change, attitude and knowledge development, and skill acquisition. While education discourse has always acknowledged the importance of wider community in the health of students, it has never been strongly supported by effective teacher development, thus ensuring that this discourse has been marginalised by teachers.

Future research could examine whether, or the extent to which, health promotion discourse has displaced health education discourse in teacher discourse.

***Question Two: “Has health education discourse been the discourse of the education sector, and health promotion discourse the discourse of public health?”***

In the older archive, health education discourses were evident in both sectors. In public health it formed part of a wider socio-environmental discourse, but it was clearly a discourse that focussed on individuals and the acquisition of knowledge, attitudes and skills for health. The same health education discourse was evident in early education sector discourses. However, over time, as I said above, the public health sector developed a health promotion discourse that replaced health education as the dominant discourse. It wasn't until very recently that the education sector began to focus on health promotion discourses and to give them prominence within a curriculum document. Because the core business of schools is education with a prime focus on individual students, it may be difficult to fully replace health education with health promotion discourses. Future research that looks at the uptake of health promotion discourse in education might look to see whether teachers view their 'core business' in relation to health as health education or health promotion and whether their views might ensure one remains or becomes the dominant discourse of the near future.

**Question Three: “How did the public health discourse of health promotion come to be a key discourse in a health education curriculum?”**

This question has been largely answered through the analysis, especially Chapter Three. Simply, I argue that the development of a health promotion discourses in public health was accompanied with a sizeable, coherent and supportive archive which included professional literature and international and national policy papers. The relative paucity of any alternative from the education sector, may have challenged the curriculum developers to attend to health promotion discourses and to include them in the health education curriculum.

**Question Four: “Are there discursive rules that govern the use of these discourses? and if so, what are they?”**

Having explored the discourses from the present day back to the 1950s, I have come to the view that present health education discourse is governed by different rules from those that govern health promotion discourse. Following the confusion and blurring that was evident during the *emergence* of health promotion discourse in the mid to late 1980s, the discursive rules for each have now separated out and become much clearer.

In order to use health education discourse in a meaningful way, there seem to be quite clear rules to guide discourse use. Health education discourse must give primacy to learning and to educative strategies including the planning of an educational process, with learning outcomes and well-defined messages, teaching or instructional methods, and assessment and evaluation included in such plans. The discourse must emphasise the individual and their health needs, their acquisition of health knowledge and understanding, their exploration of attitudes that influence health action, and their learning of a range of skills that enhance decision-making, behaviour and health action. In addition, health education discourse must include statements about the interaction of the individual with others, and with the environment. Other, lesser rules, include the use of statements that emphasise prevention of illness or injury, and that support positive holistic models of health.

Health promotion discourse is shaped by rules that give primacy to social and environmental change for health, or to influencing the social and environmental factors that

determine people's health and well-being. The rules ensure that the group, the community and the environment are emphasised. Community development, empowerment, health equity and health action are all discourses made possible by the rules governing the use of health promotion discourse. Health promotion *includes* health education as one of its strategies, and uses the discursive rules of health education use (above) when talking about these strategies. The rules of health promotion allow an eclectic range of other strategies and discourses to be included whenever they can be shown to advance the health and well-being of populations.

***Question Five: "Is the discourse of health promotion in the (education sector) curriculum used according to the discursive rules that have governed its (public health) use?"***

This is not an easy question to answer, even following the analysis of Chapters Three, Four and Five. One way of approaching the question is to look at different parts of the education sector and how each part uses health promotion discourses. For instance, the developers and writers of the 1999 curriculum show a willingness to understanding health promotion discourses and to include them in the curriculum document. There is evidence of a very real effort to bring a health promotion discourse into the curriculum. However, in doing so, there are departures from the discursive rules of health promotion usage. The reasons for these departures can not be answered here, and could form the subject of further research.

The health promotion discourse of the curriculum differs from public health health promotion discourse in the following ways. Primacy is, on balance, given to the individual and to individual behaviour change and health action, rather than to society and environment and social and environmental change (see Chapter Three). While there is an emphasis on the group, society and environment, it is not as strong as the emphasis or central position of the individual. The curriculum discourse does not clarify the relationship between health promotion and health education, leaving the rule for talking about this relationship unclear. Also unclear is the rule governing the use of prevention statements. Rules allowing the use of discourses from other disciplines are silent in the rules governing health promotion usage in the curriculum.

As an aside, the use of *hauora*, well-being, a socio-ecological *and* health promotion perspective suggests that there are separate discursive rules governing each of these concepts. In public health, health promotion discourse has rules that allow these concepts to be expressed as part of the whole discursive field of health promotion, not separate from it.

**Question Six: “Which (health education or health promotion) discourse, at any given period, came to predominate, with whom, and how?”**

This question has, I believe been well answered in the analysis and through answering Question Two. Where health education discourse was once the only discourse that allowed professionals to talk about people learning to change their health behaviours, another discourse emerged in the final quarter of the twentieth century that challenged this discourse. Eventually, by the final decade of the century, health education discourse had (in public health) been marginalised in favour of a health promotion discourse. It wasn't until the final year of the century that health promotion discourse began to predominate in New Zealand's education sector as well.

**Question Seven: “Is the curriculum discourse able to be used as a tool by any particular political ideology to gain or maintain power and dominance?”**

Finally, the analysis has suggested that the primacy given to the individual and individual responsibility for health in the curriculum discourse may serve to support a neo-liberal political ideology. However, when compared with the discourse of the 1958 syllabus, the addition in the 1999 curriculum of discourses that encourage individuals to act *for* social change for health can be seen as a discourse that stands to *resist* neo-liberalist ideology. Further investigation of this question might explore this more critically, looking at whether the curriculum discourse has affected the political attitudes of students in relation to health. Students' attitudes to who should take responsibility for health, publicly-funded health services, health insurance, and health equity, might well be the focus of such research and could serve to show the extent to which the current curriculum discourses bolster neo-liberalist or conversely, humanistic ideologies.

In addressing these questions, the problem of a health promotion discourse in a health education curriculum still remains. It is a problem for several reasons: it places new expectations and demands on teachers for which they have not been prepared, and which, many believe, lie outside their training, understanding, expertise or role. They need professional development and support on a scale unable to be provided by the Ministry of Education to meet these professional demands. It is a problem because it fails to explain the relationship between the familiar (health education) discourse and the new (health promotion) discourse. It is a problem because health promotion may be seen as a 'foreign' health sector discourse and therefore inappropriate for use in an educational setting. And it is a problem because it has the very real possibility of alienating teachers from support for this curriculum area. If this happens, then the trends in Great Britain and many education districts in the United States may be repeated here - the loss of this curriculum area from the compulsory national curriculum framework.

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